





THE  
SCIENCE  
OF  
CHIROPRACTIC

VOL. III.  
PALMER  
1908



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Davenport, Iowa., U. S. A.





To "Uncle Howard" Nutting who has labored with the workers of this philosophy and the science itself ; who has helped its material steps unceasingly ; has placed its interests first, time and again, to the detriment of his daily avocation and whose writings have materially advanced the progression of Chiropractic from an art to a science and, in recent years, from science to a philosophy of Chiropractic, is this work dedicated.

THE  
PHILOSOPHY AND PRINCIPLES  
OF CHIROPRACTIC  
ADJUSTMENTS

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A  
SERIES OF TWENTY FOUR  
LECTURES

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Delivered by  
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THE PALMER SCHOOL OF CHIROPRACTIC,  
"CHIROPRACTIC'S FOUNTAIN HEAD"  
Davenport, Iowa, U. S. A.

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Universal Chiropractic College

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Jan. 1908.



B. J. PALMER, D. C., PH. C.



## PREFACE.

The public have been bored with therapeutical books for centuries, yet previous attempts have never given complete satisfaction, they but created yearning for a something that is definite, does not require great labor, can be relied upon in all cases, something that is certain to deliver what is wanted, so that the head of each home can be his own health giver without enormous doctor bills—"something that just fills the bill." The masses are groaning with the miscarriages of justice that they have been forced to accept thru allowing others to think for them. Some books are of great pretensions, others offer plausible intentions, endeavoring to use compulsion to make you believe something against which your judgment, if faced with the deception, would revolt.

Nothing is farther from my intention than to disparage their several aims. Honesty exists in all ranks, in that they *try* to reach perfection thru superstitious and mythical means. Therapeutics is wrongly based. It needs one vast revolution—this is the mission of Chiropractic—the first *non-therapeutical* theological philosophy. Christianity made a reconstitution and "revelations" and "miracles" of those days are being accomplished today along lines which utilize the same powers with identical intents.

The mission of ministerial work is to draw mental man nearer to God, the work of a Chiropractor is to allow God full expression *in* the physical *and* mental man. Does the present day "preaching the gospel" performing operations or dosing with drugs accomplish the aim? If not, *then something is radically wrong*. You must be teaching, believing or pinning your faith to prescriptions and the knife, none of which are consistent or in accord with simple facts.

Instead of building mysterious ideas in atmosphere and thru that, ultimately hope to reach the root of mental and physical evils—if possible; reverse it, let your first question be "What is life—death—and the intermediate, disease"? Answer these theologically and philosophically and you will have reached a fundamental—providing—you can bridge the gap between the etherial and the physical, if so, you are a candidate for further wisdom but not until then.

I do not wish to question the claims of professional ability that we do not see, for its records are too well implanted upon the memories of all, well knowing that if merit is between the lines it will ooze to the surface with results, if stalled in the mire then more than pleas and supplications to God are necessary to return health so that all, laymen and professionals, may see, partake of freely, and perform such work. No man leaves the fallible of yesterday for a truth of today without a mental tussle with self or the fellow-mortal that presents it, but in truth and justice it must be confessed that as far as other works relate to or copy from what it taught at *The P. S. C.* in the philosophy, science, and art of Chiropractic, their authors have not escaped the common error of superficial reasoning along materialistic lines. They overlook the fact that the average reader is not grounded in the simple, true principles of what, where and how Innate Intelligence thru your brain, reaches you and me and thus the lack of knowledge of the complete circuit maker or breaker has allowed stagnation to revolve around this corporeal circle with no start or end, upon the part of the doctor or patient; each has aimed to take advantage of the other's stupidity and, without assigning reasons for this or that conclusion they continue to force beliefs or dogmas. Disbelief but repeats itself thru trials, then a fashion of today is born and dies tomorrow. As one writer has said "They are trying to sail the ship of science and art, over the seas of life, without a philosophical intelligence to guide it." This was the condition of affairs at the time Chiropractic was born. Man was forced to consider that "phenomena occurred" without thot or a creative mentality. "Phenomena happened" by "sympathy" after playing hide and seek thru dozens of belly and spinal brains, etc., which was sufficient to settle the subject. *How or why* were questions looked for in things entirely corporeal or wholly spiritualistic, neither one tried or dared to unite the forces of the one with the other. It has remained for Chiropractic to prove that they can and do work hand in hand with each other.

Proceeding generations have been taught the intricacies of sailing into and thru your material ship of state at a school equipped for that purpose; they have pur-

chased materials galore with which to accomplish this mission. Yet Christ walked this earth without the methods of therapeutics known today and accomplished cures that, today, would awaken the most rebellious actions upon the part of the present day ethical practitioners.

The intellectual reasoning that guides your or my bodies, supplies them continually with power, keeps bodies warm, sees that we get nutrition, repairs our bones if fractured, cures us if sick, etc., from birth to death, has been overlooked; its values and what can be accomplished by allowing *that force to work in unison with the physical* has been too deep for any past mind to link with the material. Many an individual has assumed either the spiritual issue as "all in all" or the materialist has said "physical is ruled absolutely by corporeal elements" but it remained for the last two years to issue Chiropractic philosophical work to fully and unquestionably prove the bridging of this chasm.

I am not acquainted with any book, in any of the sciences that is calculated to furnish such teachings as will enable the philosopher to accomplish that specific assistance, or one which professes to drill the student into the ground work of simplified, corelated facts regarding the source of all power (Innate Intelligence) its mannerisms, means and ways of showing itself, how it supplies the physical body with its daily wants ("Give us this day our *daily bread*") or has even made of that theosophy a science, art, and philosophy which can be and is practiced by manual means, in daily execution *and positively links one with its counterpart*.

The following chapters were delivered in daily recitations at *The P. S. C.* as "short talks" about the vertebrae and the various points of knowledge most necessary. When finished I was urged to illustrate the ideas and then print them. Vol. 3 is the result.

Numerous are the works that present us with conglomerated, juggled details of either one extreme or the other of this issue, but not one with a philosophical union, proven practically, other than what exists in **THE SCIENCE OF CHIROPRACTIC, VOLS. 1 & 2** as well as

Vol. 3 in which all research and investigation has been confined to the study of the *backbone* of all creative faculties and its counterpart, expression, and allow God physical personification without hindrance or interruption in a temple of his own making. It is the means whereby all of this is accomplished that has prompted the publishing of Vol. 3.

*The P. S. C.* library, as well as others, has books, good, bad or indifferent but none ventured to discuss the laws of forces, powers, or the study of biology and then make a union with its mediums. Where your creation received its intelligence, or by what means it is personified, has long been considered unnecessary, nor have they attempted to explain the essential parts which each is supposed to perform in the general scheme of the expressed likeness of God; they cannot therefore lead to any generalization or localization of focalized ideas. With such unstable premises Chiropractic had a herculean task before it; thon has met handshakes from friends and rebuffs from strangers, yet is steadily gaining new adherents who are sincere and wish a higher enlightenment. Too often the young or new practitioner is apt to take things for granted because "it always has been so" or "it is printed in Gray's Anatomy" (and many times contradicted in Dunglison's Dictionary,) without reasoning along original lines or doing independent thinking. What he needs is the beacon of Innate Intelligence as the first rock, then bring into action latent forces, and let those conclusions lead him into ascertained and proven facts regardless of whether books say it is or is not so, the product of his ambitions will be original. His ship will not be abandoned upon the shoals of despair by one of two evils—a feeble and servile routine of mumbled words, of a wild and lawless empiricism.

This issue aims to supply this deficiency, by proving, step by step, how your physical machine can be adjusted to a philosophical one, making a unity between the hobbies of spiritual life *and* physical demonstrations, and portrays how this is accomplished—it leads you from supposed knowledge to facts.

That the design of the present work may not be mistaken, it is essential to remark that we take it for granted

that you have studied the *philosophy* contained in THE SCIENCE OF CHIROPRACTIC, Vols. 1 & 2 and are therefore ready to accept what is contained in Vol. 3. Without its predecessors this is Greek; one must go with the others. Many practitioners enter this school thinking to add Chiropractic to what they previously had—*this is impossible*. This philosophy, rightly understood, is so based that the fundamental of one will not—*cannot*—mix with mythical theories propounded for centuries. It is too modern for that, and yet we are but deciphering and placing into intelligible words that which has always existed, the laws of God, and that is why the cruder (?) and lower (?) order of intelligences, in natives of various countries, *all have some form of manual treatment applied to the spine* for they are closer in communion with their Creator and His ways of doing. They work *towards* and the present day scientist *from* inevitable laws.

The aim thruout this book has been to explain subluxations and their adjustments around *six* words, viz; superior, inferior, left, right, anterior and posterior. With these any combination can be elaborated upon. Like the mariner's compass the four directions, viz; North, South, East and West tells every direction he wants to go or has come from.

Every author or compiler is aware that the camera does not reproduce as keenly as the eye sees; also that each step, from the photograph to that of reproduction on book paper from the half tone, has a tendency to withdraw detail that he might have wished to reproduce. Having this knowledge I have purposely exaggerated the positions of many of the portrayels to carry the conception so that its intentions could be readily grasped by the lay or professional mind alike.

I wish you to remember that such abnormalities could and do exist as proven by post mortems and the innumerable specimens of *The P. S. C. Osteological Collection*, but, the majority of patients, which general practice gets, exist in more minute form with the consequences to correspond. To reproduce the subluxations etc., as they are usually found upon minute palpation would be so slight



(compared with the illustrations) that the specific intents would be lost. With this explanation I commend the illustrations, in Vol. 3, for your study.

Chiropractic existed as an art for the first 3 years; as a science for 7 years and as a philosophy for the last 2 years. Its principles were not worked out; it remained for minds other than the discoverer's to ferret them out and then use their ability to present them to the lay, or trained mind.

In this work, not only does the language in which ideas are couched belong to the author, but the very thoughts themselves were his from their inception. Upon him has devolved the labor of their development. Even the methods used in illustration (with the single exception of the position of the hands in adjusting) are the children of his own ingenuity.

In some of the pages we have repeated the point numbers without filling them out. We wished to avoid repetition; it is tiresome to the reader and has no gain. This body is but a repetition of seven primary functions and when put thru a Chiropractic analysis shows that all are the same with a different location of effects and cause and a name to correspond.

Books have been written, some with intelligence and others without it, others for scientific reasons; more on the viscera and tissues and less about the spinal column and its philosophical value, than any other subject in medical annals, but *this* book has the distinction of being *the first* to exclusively confine itself to the vertebral column conveying the knowledge that each and every vertebra is the physical representative of the cause of many abnormalities existing in near, or distant portions of the body. It teaches you to rely upon the forces *within* man to correct its subluxations, it proves the capability of one man to adjust another even if lost in the woods with Mother Innate's tools—mind and hands. No adjuncts need knock. Should disease *exist* adjust the cause, then look internally for the power that heals.

It is with the hope of further establishing the individuality of Chiropractic that we publish this book know-



ing that it will fill a niche that has never been approached before, and that no one is more capable of presenting this philosophy distinctly upon an independent footing than the man who has spent many a month in deducing a reasonable, simple, scientific manner of always knowing just how and where these philosophical connections can be made, where exists all the switches that turn on or off the Innate currents to depleted, atrophic or hypertrophic tissues. Other minds have come and gone, performed their share, be it great or small, of these labors and several times have been forced to drop the burden that became too heavy, for it requires more than mental or physical strength—it needs steadfastness of purpose, *righteous* principle and superior observation to succeed in advancing a theosophical philosophy and convincing the masses that it can be and is, for the first time, adjusted to a practical art and science.

Pt. 12 is considered broadly, altho the intentions were to make it thoro by listing the diseases that are adjusted there, but its size soon proved that that would be a book in itself. Pt. 12 was then revised to convey a general knowledge of the areas and localities involved. I am now working on "*Causes Localized*", Vol. 4 of *The Philosophy of Chiropractic*, which will be a dictionary of technical and lay names for all diseases *and where to adjust for each* that it would be impossible to issue here.

Each year sees further independent progress in making this compilation of two elements, united into one co-ordinate whole, a vast movement which will create the greatest unrest in therapeutical ranks the world has ever known, for upon the strength of this non-therapeutical agency and the consequential health of mankind depends greater future intellectual progressiveness and all that advanced ability creates and rules.

The progress during 1907 has been nothing short of the energies spent in endeavoring to set a pace that is now creating a furore in superstitious ranks. If this volume will but help to continue that movement, then it will have fulfilled its mission.

It is with the hope that I may be able to propagate our already acquired knowledge so that its usefulness may

be more widely extended; and, by offering this collective arrangement of the vertebrae, and how each may be subjected to concussions and subluxations consequently and diseases subsequently, and how that acts as a circuit breaker between currents, mental and physical; and then how to again make a philosophical cycle of life creation and health expression in contradistinction to life creation but lack of expression—disease—and to establish this philosophy of Chiropractic upon a more simplified, scientific basis and thereby render its future career one of improvement and progressiveness with that of other branches that *The P. S. C.* has brought forward, or to follow up the figurative illustration, already introduced, to furnish the pilot of the boat with the knowledge of how its course is wrong, how to read the compass and then give instruction how to steer the steamer in harmony with Innate Intelligence so that your craft will land at the welcome port of Health and satisfaction. Chiropractic, conveys you, as a disciple, to the ship, and at the same time teaches its intricate workings and guides you thru all the shallow and treacherous channels that offer themselves at every turn of the course.

B. J. Palmer, D. C., Ph. C.

Pres. & Sec., *The Palmer School of Chiropractic*,  
"CHIROPRACTIC'S FOUNTAIN HEAD" Davenport,  
Iowa, U. S. A., Jan., 1908.



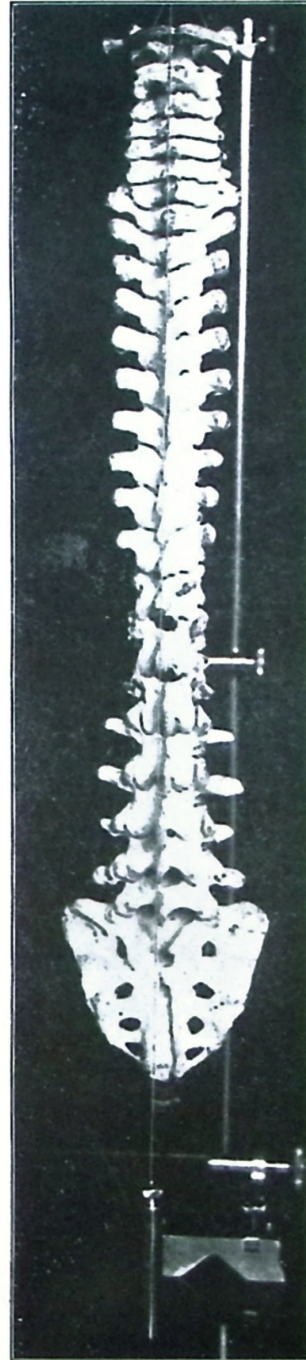
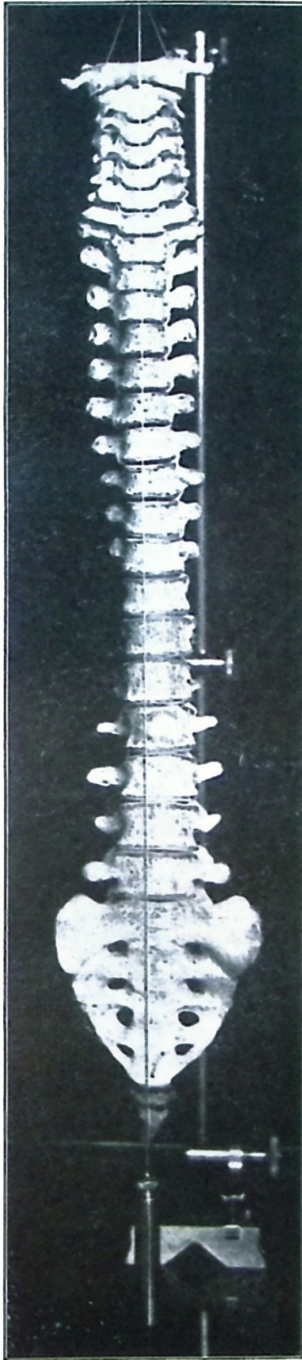


Fig. 1. Spinal Column. Fig. 2. Spinal Column.  
*Anterior view. Posterior view.*

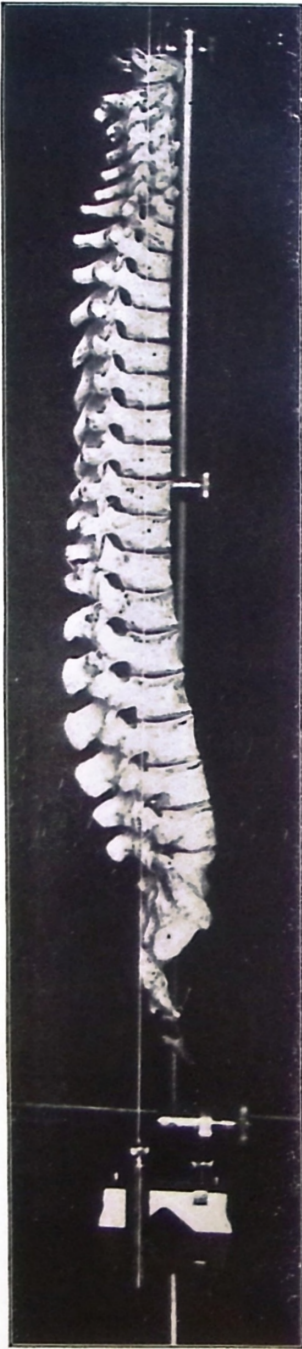


Fig. 3. Spinal Column. *Right view.*



Fig. 4. Spinal Column. *Left view.*



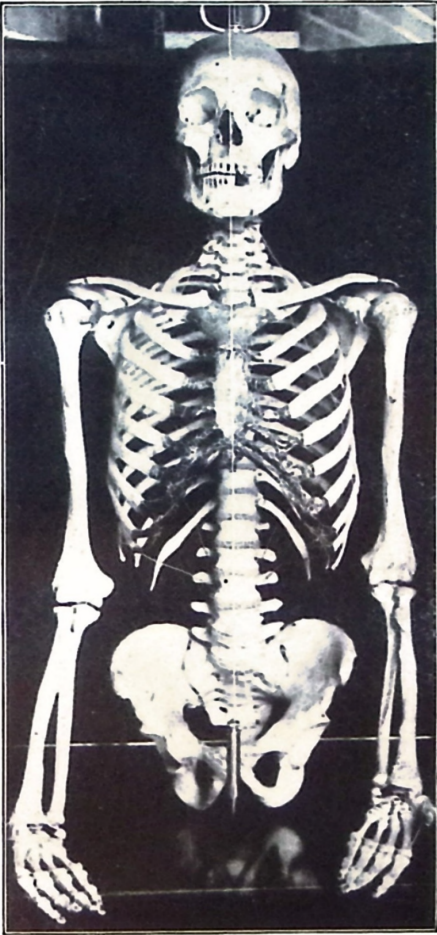


Fig. 5. *Anterior of torso.*

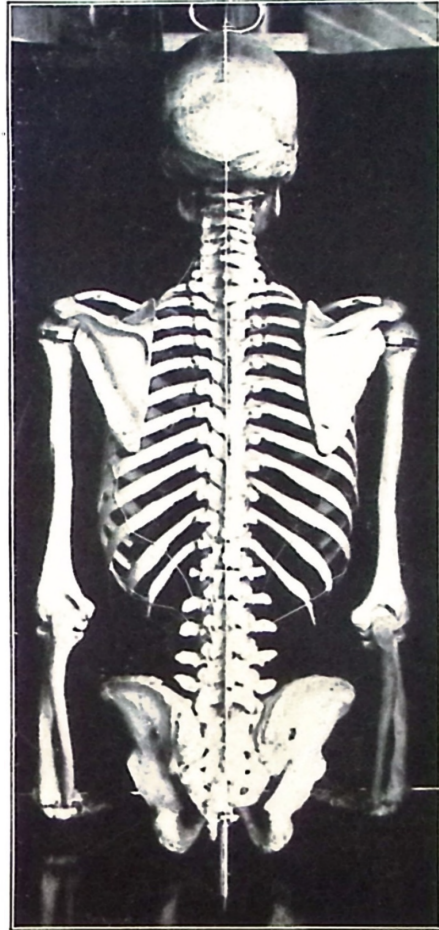


Fig. 6. *Posterior of torso.*

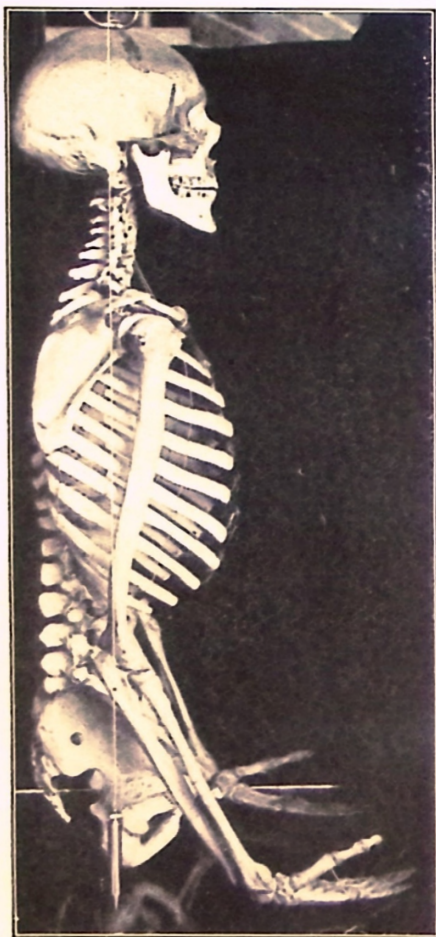


Fig. 7. *Right* lateral of torso.



Fig. 8. *Left* lateral of torso.



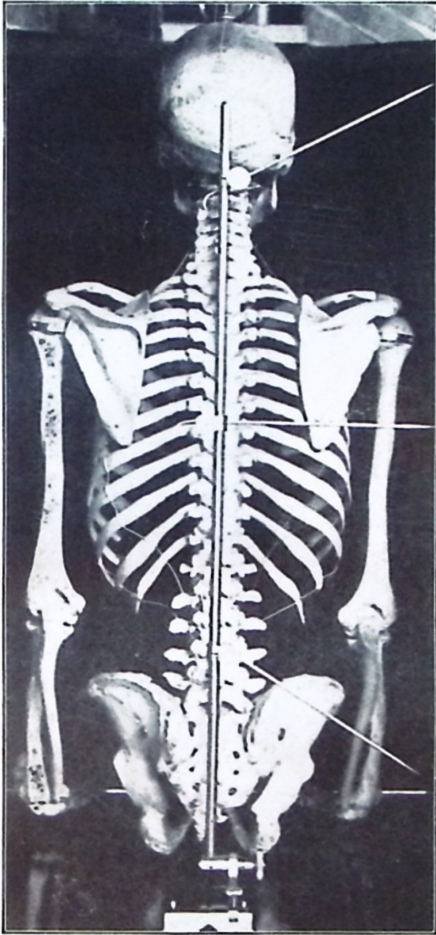


Fig. 9. *Posterior of torso, showing right superior, right, and right inferior directions.*

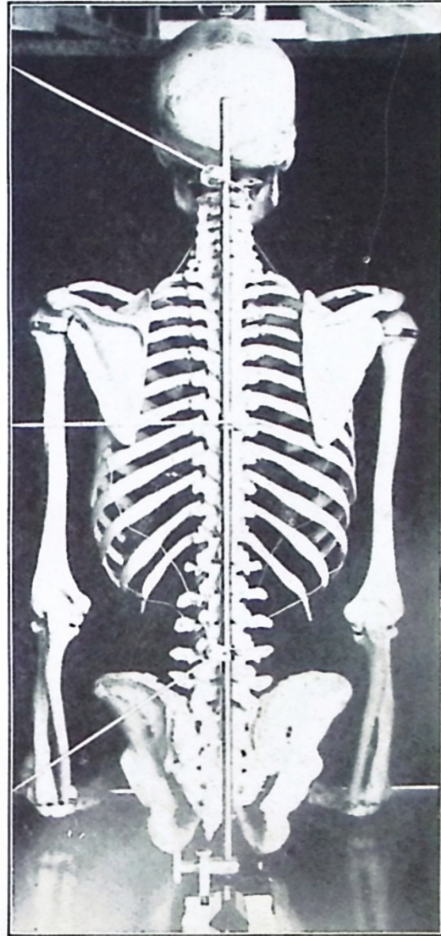


Fig. 10. *Posterior of torso, showing left superior, left and left inferior directions.*

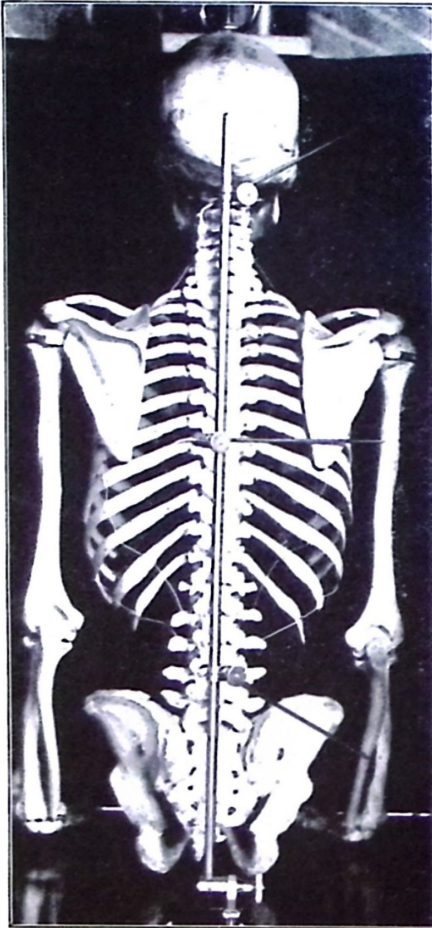


Fig. 11. *Posterior of torso, showing right superior anterior, right anterior and right inferior anterior.*

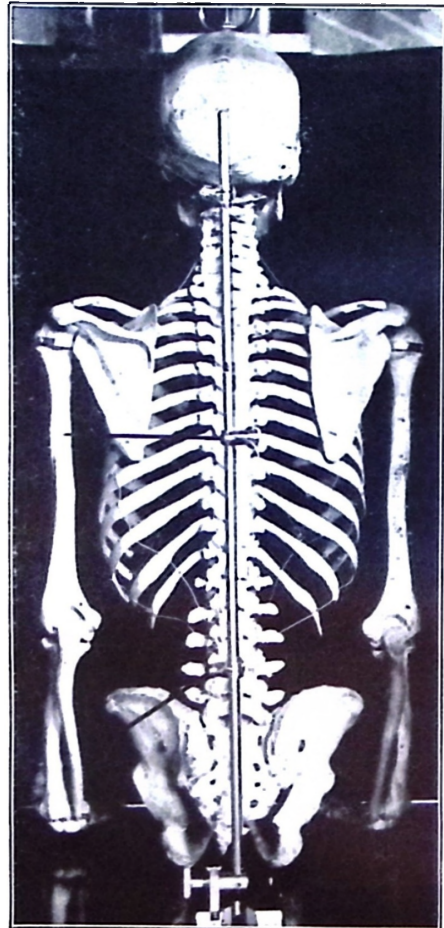


Fig. 12. *Posterior of torso, showing left superior anterior, left anterior and left inferior anterior.*

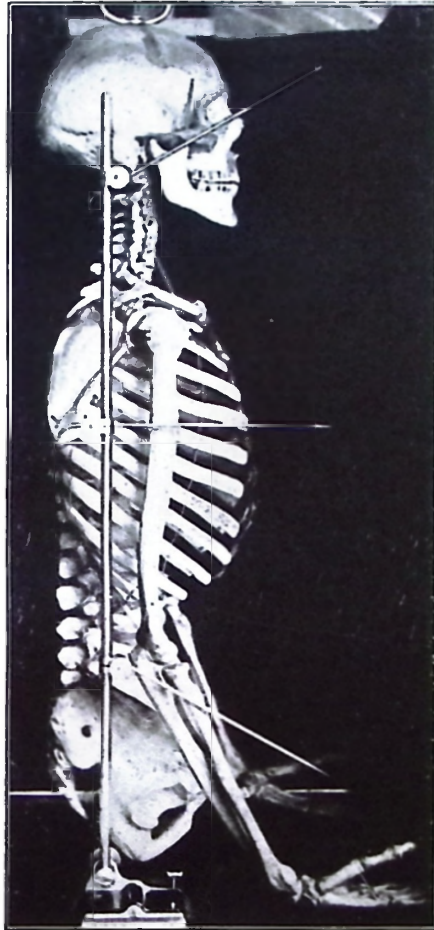


Fig. 13. Right lateral view of torso, showing *anterior superior*, *anterior* and *anterior inferior*.



## THE VERTEBRAL COLUMN.

## CHAPTER I.

The spinal column consists of thirty-three irregular bony segments, the vertebrae, of which the upper twenty-four are separated during life by disks of fibro-cartilage, and are therefore called the true or movable vertebrae in contradistinction to the lower nine, which are named false or fixed vertebrae, because they become consolidated into the sacrum and coccyx. The true vertebrae are further designated according to the region which they occupy in the skeleton—the *cervical* vertebrae including the upper seven, the *dorsal* (or thoracic) the succeeding twelve, and the *lumbar*, the lower five. All consist of two essential portions, an anterior cancellous bony disk, the *body*, or *centrum*, and a *posterior* compact bony arch, which is attached laterally to the posterior surface of the body. They are both variously modified in different localities to serve special purposes. The bodies are connected thruout the series by the intervertebral cartilages, which are attached to their upper and lower surfaces, and by strong elastic ligaments, forming a flexible support for the head and trunk, while the arches with their intervening ligaments form the protective neural canal which encloses the spinal cord.

The bodies generally are fastened above and below, presenting broad roughened surfaces with elevated rims at the circumference, which project slightly in front and at the sides, where the middle portions are narrowed. The latter are somewhat concave from side to side posteriorly where they contribute to the formation of the neural canal.

The arches present upon their convex surfaces seven variously developed processes. Of these the spinous processes project backward in the middle, are more or less conspicuous through the surface tissues and by far the most important to the Chiropractor. The series of spinous processes are collectively sometimes called the spine. Each of them has a pair of lateral ridges terminating in a tubercle, and a median ridge with a tuberosity. The transverse processes project outwardly on each side of the arches between the articular

processes of which there are four facets two projecting upward and two downward, to join with the opposed facets of the contiguous vertebrae.

The portions of the arches between the spinous and the articular processes are flattened, shelving bony plates with roughened edges, the laminae, and the strong rounded portions between the articular processes and the bodies are the pedicles.

The spines through the entire series, except those of the first cervical vertebra, may be brought into relief and detected by sight as well as by touch by bending the body forward. They never occupy an exactly straight line, being normally slightly divergent to the right, in "right handed" or to left in "left handed" people, in the thoracic portion of the vertebral column, where they are obscured in the upright position except when the body is emaciated. It should be remembered, that owing to the obliquity of the vertebral spinous processes in the thoracic portion of the column they are not opposite the corresponding vertebral bodies. The third dorsal spine is about opposite the bifurcation of the trachea. The sensibility of the dorsal region or any zone of the back is low as compared with the corresponding anterior of the body.

This can be tested with anything of a given size on either or both sides. The entire column composed of the vertebral bodies and disks of fibro-cartilage, is ensheathed with a continuous layer of white fibres, intimately associated with the periosteum, which, owing to its greater thickness in front and behind is specialized into two bands, called the anterior and posterior common ligaments.

The anterior commences at the anterior tubercle of the atlas, between the longus colli muscles, and descends along the front of the column to the coccyx.

This ligament consists of several layers, the outer, composed of long fibres, extending over several vertebrae, and the inner, of short fibres, from one vertebra to another. It is thicker over the bodies of the vertebrae than over the intervertebral disks. The posterior ligament is within the neural canal, extending from the anterior border of the foramen magnum to the sacrum, and being attached to the posterior surfaces of the vertebral bodies and the disks

throughout its course. It has a scalloped appearance when examined in its entire length owing to its being narrowed and thinned opposite to the middle of each vertebral body for the exit of the *venae basis vertebrarum*. It also consists of several layers, the fibres of which are disposed similarly to those of the anterior ligament. The inter-laminar ligaments (*ligamenta subflava*) fill the intervals between the neural arches. They are thick bands of pure yellow elastic fibres attached to the roughened edges of the opposing laminae above and below.

They are continuous from side to side, uniting beneath the spinous processes and giving origin to the interspinous ligaments. They consist of double layers of horizontal white fibres extending from the median ridge of each lower spine to the inter-tuberos space of the spine above. They are variably developed in different localities, being especially weak in the neck.

The supra-spinous ligament consists of a continuous longitudinal band extending along the series of spinous processes. It is inseparable from the lumbar fascia, and is specialized in the dorsal region as the *ligamentum apicum*, and in the neck as the *ligamentum nuchae*.

The average length of the vertebral column in the well formed adult *male* is about *twenty-seven and three-fourths inches*, and in the *female* *twenty-seven inches*. When viewed from side to side the bodies are seen to increase in size from above downward, forming an elongated cone, and when in the erect position *the line of the center of gravity passes through the column from the odontoid process through the front of the body of the second dorsal, the middle of the twelfth dorsal, and the border of the last lumbar vertebra*.

At birth the infant's spine is quite straight, serving merely to connect the head, limbs, and ribs, and as a protecting column to the spinal cord. It is very flexible at this time, and totally without the important factors of gravity and muscular contraction which, as the child begins to sit, stand and walk, tend to produce the characteristic curvatures in the neck, back and loins.

These curvatures are not fully developed until adult life; and, as the spinal column owes to them its elasticity



and power of withstanding various abnormal forces communicated to it, they are deserving of special mention. In the back of a young child, especially if it be delicate, or subject to rickets, there will always be noticed a general curving of the column backward.

In fact, this convex curvature of the back is that which persons naturally assume when feeble or weary at any period of life. Subluxations produce habits or occupations that make the curvature more pronounced. The dorsal and pelvic curvatures, made up of the sacro-coccygeal vertebrae, are the natural ones found in the infant. In the embryo, at the very beginning of the formation of the column it assumes this dorsal convexity, and as soon as the sacral promontory is developed, it is modified only by the addition of the pelvic curve. The normal curvatures of the spine are maintained to a great extent by the disks of intervertebral fibro-cartilage, which are most developed in the region where most movement is allowed. The disks act as buffers in resisting shocks and contribute very much to the elasticity of the spine. The natural curves are all anteroposterior with a very slight deviation to the right in the thoracic region, as already stated.

The erector spinae muscles occupy the gutters upon each lateral transverse process and tend to establish equilibrium. The motion which the muscles are capable of producing in the spinal column are lateral, antero-posterior, and rotary. The greatest degree of rotation and lateral flexion is found in the neck and loins. Structural changes are the result of unequal muscular contractions (due to pressure upon the nerves, which transmit the output of mental impulses, thus hindering the flow to the muscles of that region) producing deformity. When the curvatures are exaggerated they are called hyphosis, lordosis, and scoliosis, according as the convexity is directed backward, forward, or laterally. The first deformity or cyphosis, is seen in rickets or in caries of the bodies of the vertebrae.

The lordosis, or saddle-back, is produced by subluxations of vertebrae, in a continuous order, and the scoliosis, which is the most frequent, is generally met with among people who have injured themselves by overlifting, wrenching or subluxating one or more vertebrae. *Is is an in-*

*variable rule with regard to spinal deformities that if a weakness occurs at any point which occasions deviation, there will arise compensating deviations above or below it.* In marked cases there will also occur a rotary curvature, caused by the contraction of the muscles, pulling harder than normal, due to a local cause. These are sometimes so powerful that the transverse processes are adapted into the usual position of the spines.

The most frequent seat of lateral curvature is about the fourth or fifth dorsal vertebra. The most movable part of the spine is at the junction of the twelfth dorsal and first lumbar vertebrae, *and here the back is most liable to injury from strain.* There is very slight motion between any two vertebrae, but the degree of movement resulting from the sum of the motions between the contiguous vertebrae of the series, is considerable and is variable in different individuals according to the number, degree and severity of vertebral subluxations. It can be increased by proper adjustment of the superior or inferior subluxations as seen in those who have none—contortionists, who can bend the spine backward so that the head can be brought forward between the thighs.

The weight of the head and upper extremities increases the convexity of the back and compresses the intervertebral disks, so that at night the ordinary stature of the adult is diminished about half an inch, from what it was on rising in the morning.

## CHAPTER 2.

## DEFINITIONS.

*The vetebral column*—is that *vertical line shaft* of man or beast expressing mechanical actions; it supports the body, protects the spinal cord, permits flexion, rotation, extension, and counter-extension in any and all directions.

*Sub-luxation*—is that condition where one articular surfac partially loses its normal relation to its co-respondent *regardless of the conditions of surrounding tissues*.

*Vertebral Palpation*—is that mode of exploring or ascertaining the *precise* position of vertebrae by pressing, feeling and exploration with the highly sensitive, trained fingers of one or both hands, to determine the *exact* relative location comparatively with the superior and inferior vertebrae.

*Function*—is that normal cellular *expansion which expresses the mental equivalent, personifies the intelligent thought*, and completes the transformation between innate power and physical interpretation.

*Analysis*—is the *resolving of functions, normal and abnormal*, with their comparative qualities and quantities, *back to location and character of its or their cause or causes*, and the consideration of constituent manifestations of life involved; *the tracing or retracing of material abnormalitics*, forward or backward, *to their source of Innate Intellectual origin; the detailed segregation, step by step, of original principles from mental creation to physical expression or vice versa*.

*Pressure*—That condition where nerves or nerve fibrillae (soft substance) are entirely surrounded by osseous (hard structure) intervertebral foramina, the lumen of which decreases in size and shape according to the constriction thereof, producing a squeezing or crushing upon the contents passing through, thus decreasing or intensifying the quantity or quality of Innate intellectual resistance or adapation. Universal Chiropractic College

*Nerve Tracing*—is that exact, searching, physical palpation made by the Chiropractor upon the patient to



*prove the direct philosophical connection between Innate Intelligence and tissues, starting at location of function abnormally expressed; to analyze the path or paths of a nerve fibrilla or fibrillae which transmit the connective life elements in normal or abnormal, to ultimately reach the specific subluxation and site of pressure. The subluxation being prominent and first considered, the plan of procedure is reversed viz; proceed from that to locality of disease.*

*Adjustment—the connecting of Innate Intelligence into thorough and unhindered relation; restoring mental co-ordination with the physical elements to make one unit; the name given to what a Chiropractor does when he restores equilibrium between the above two essential principles—creation, etherially and expression, physically; hence to liberate occluded foramina through which immaterial atoms of life should be constantly transmitted; to release pressures upon nerves; to return absent fundamental inherent intellectual power; to adjust deranged equipoise between Innate and the physical.*

*Brain Nerves*—is used to express the additional idea of the place of origin of *all* nerves in contradistinction to the terms “spinal”, “cranial” or “sympathetic nerves”. To *The P. S. C.* philosopher, all nerves originate within the brain and those with which he will have to deal have emergence in cables at the magnum foramen, the aggregation of which cables, is the spinal cord. In this form they proceed downward and have many points of emission thru intervertebral foramina passing to all systems of viscera, organs and tissues. *Brain nerves* are the material connection between brain and tissues, conveying thru them the impulses that are transformed in the brain and then propelled over these transmitters to express their individual characteristic action. By this means a continuous circuit between the seat of all intelligence (the mind or Innate Intelligence) is established. Break the circuit completely and death, or partially by subluxation, and disease, are the relative products. The Chiropractor has no “spinal” or “sympathetic nerves” to worry about. All fibres expand from the brain, thus the preference for “Brain Nerves.”

*Anterior*—to the *front* of the body. “Before, or toward the front.” *Webster*.

*Posterior*—to the *rear* of the body. “Situated behind.” *Webster*.

*Superior*—*above* the object referred to; elevated to that which is considered. “More elevated in place or position.” *Webster*.

*Inferior*—*below* the given point being studied. “Lower in place, rank.” *Webster*.

*Left*—to that *side* of the median line of the normal position of the vertebra or vertebrae investigated.

*Right*—the opposite of left.

These terms are used to designate the normal or abnormal positions of a vertebra or vertebrae, also indicating the direction to which it or they must be adjusted. Each is used regardless of whether the patient stands, sits, or lies; no matter what position or angle then may be in.

## ORDER OF SUBJECTS.

1. Vertebra and its title.
2. Superficial palpation and land marks.
3. Normal position and articulations.
4. Subluxations described and illustrated.
5. Relative positions of adjacent vertebrae.
6. Where nerves are impinged.
7. How and what makes pressures.
8. Functions and organs involved. Location of—
9. Adjustments necessary to correct each.
10. How to give adjustments correctly.
11. What means, and portions thereof, to use.
12. What diseases to adjust this vertebra for.



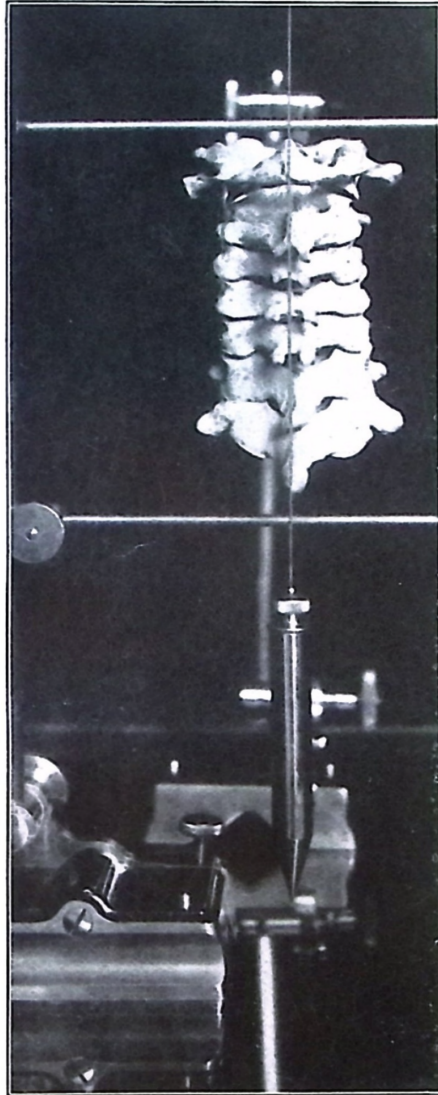


Fig. 14. Seven Cervical Vertebrae on standard. *Posterior* view. Notice relationship between all spinous processes and position of plumb line.

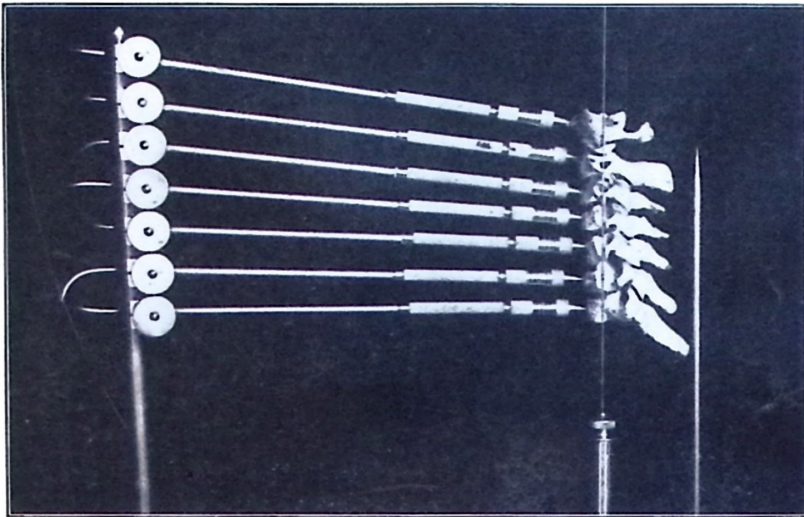


Fig. 15. Left lateral view of seven cervical.

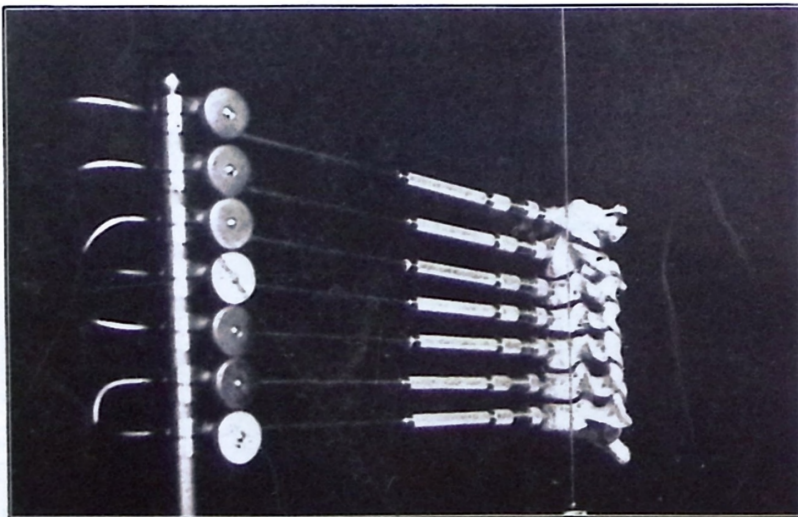


Fig. 16. Left latero-posterior of seven cervical showing foramina thru which brain nerves emit.

*CHAPTER 3.***THE CERVICAL VERTEBRAE.**

These are the smallest and most delicately constructed of the entire column, and are especially adapted to the great mobility of the neck. The bodies are generally concave from side to side on their articular surfaces, owing to the elevation of their lateral borders, and concave from

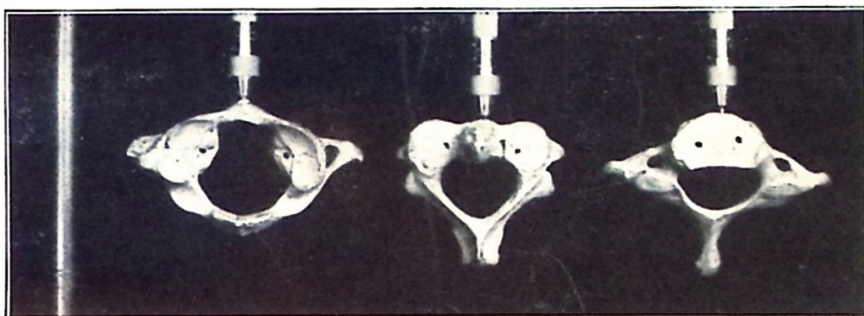


Fig. 16-A. The three peculiar cervical-Atlas, Axis and 7th. Superior view.

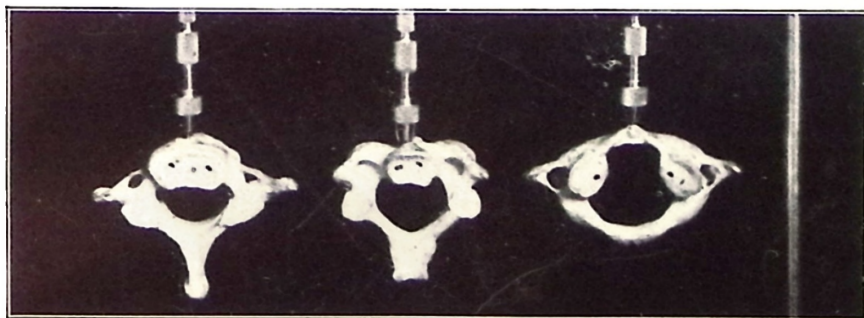


Fig. 16-B. The three peculiar cervical-Atlas, Axis and 7th. Inferior view.

before backward, in consequence of the front border extending downward. The arches are broad but comparatively shallow, and the spinal foramen which they enclose is heart shaped gradually enlarging from the second to the fifth and diminishing from the latter to the seventh.



The spinous processes vary very markedly, being wanting usually in the first cervical vertebra, large and strong in the second and seventh, and small and bifid in the intermediate vertebrae. The laminae are long and narrow, while the pedicles are directed backward and outward. The articular processes, situated at the junction of the laminae and pedicles, have their surfaces directed upward and backward above, and downward and forward below. The transverse processes are not strongly developed, but are reinforced by the costal processes which extend from the sides of the body and join the transverse processes at their extremities by a bridge of bone, thus enclosing the vertebral foramen.

The costal process in connection with the seventh vertebra is sometimes developed as a movable cervical rib. Seven large ones of this kind are in *The P. S. C.* osteological collection.

The cervical vertebrae which present especial features are the first, second and seventh.

Subluxations of these vertebrae are common. The Atlas (presenting special features) and the 4th, are most commonly subluxated, the Axis would be a close third, the balance diminishing as they go from these centers.

## CHAPTER 4.

## ATLAS.

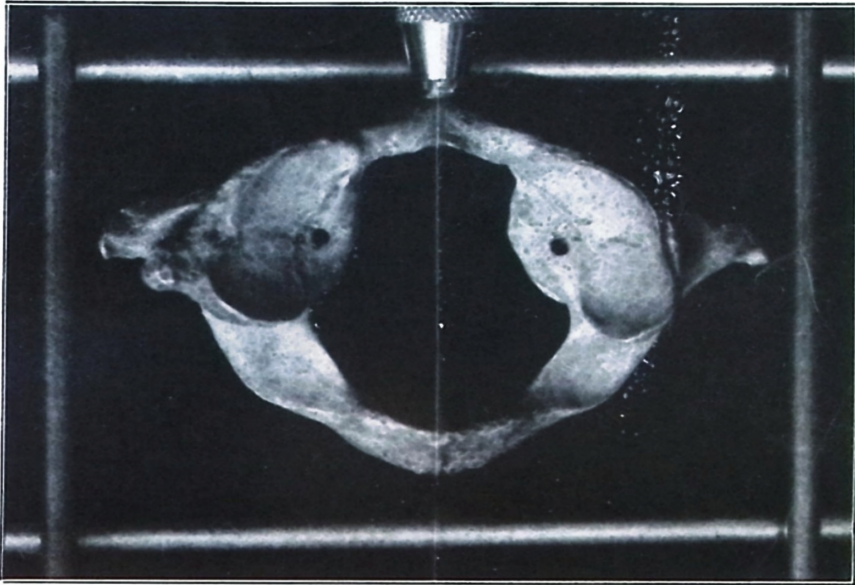


Figure 17.

1. *Vertebra and its title. At P.*

Atlas is the fifth vertebral expansion, considering the four superior cranial vertebrae as its predecessors. Atlas is the first *true*, freely movable vertebra.

2. *Superficial Palpation and Land Marks.*

The first cervical vertebra is called the atlas because it supports the head. It has the appearance of a bony ring, consisting of two arches joined by two broad lateral masses. The posterior arch is more delicately formed than the anterior, but twice as long. On its posterior surface there is a rough, blunt tubercle, but no spinous process, because any such projection would interfere with the freedom of its rotation. The atlas is of greater breadth than any of the succeeding cervical vertebrae, and the lateral masses present, on their upper surfaces, irregular articular facets, which are invariably constricted and have their outer borders raised for the reception of the condyles of the occipital bone. Their shape is adapted to the nodding movements of the skull.



Fig. 18. *Right antero-lateral of torso. Skeleton sitting showing how and where fingers are placed in palpating for transverse process of atlas.*

Fig. 19. *Anterior view of superior of torso, skeleton sitting, showing both hands in position. Palpater always stands to the rear and compares both sides.*



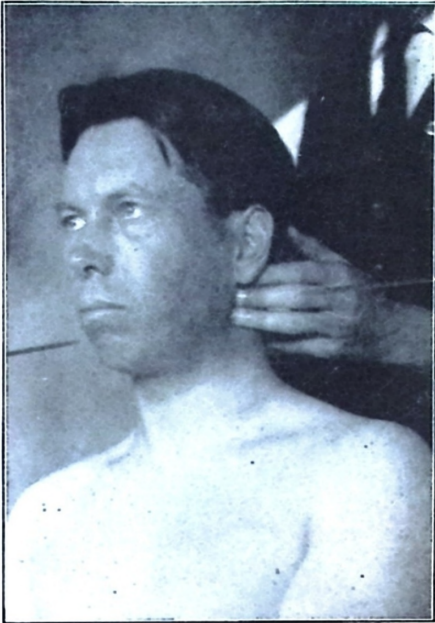


Fig. 20. *Left* antero-lateral of patient sitting, showing how to palpate for transverse of atlas upon living subject.

Fig. 21. Sometimes the atlas is superiorly imbedded. To ascertain its exact position have the head thrown backward increasing the size of the crotch.

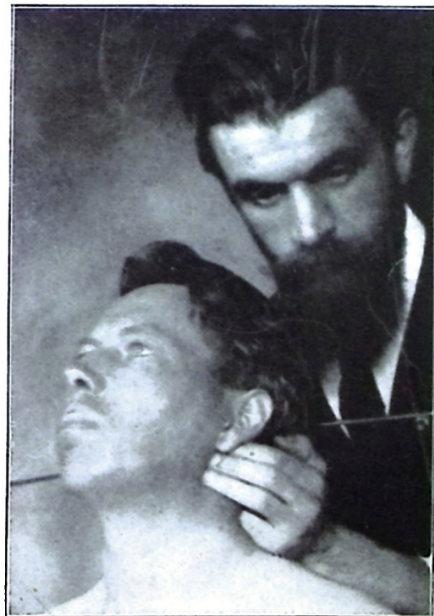






Fig. 22. Head flexed forward to increase the posterior size of the crotch. Palpation is always with three fingers.

Fig. 23. Palpation of atlas. Patient prone, with face flat on table making the same position as illustration Fig. 20.





Fig. 24. Palpation of *right* transverse, face looking toward camera.

Fig. 25. Palpating both transverse, head on chin, giving the same position, prone as Fig. 21. Notice thumbs are on median line, posteriorly, to compare positions from right to left.





Fig. 26. How to find lamina of either side. Find the spinous processs of axis and transverse of atlas and bisect the space between.

Fig. 27. *Posterior* view showing the same as previous Fig. The center finger drops up-on the lamina of atlas.





Occasionally the laminae may be felt by examination under the occipital and laterally to the median line. Very rarely it has a spinous process observable at the posterior median line in close proximity to the inferior median of the occipital bone. Its transverse processes, in normal, are always to be felt at the crotch of the condylar processes of the ascending ramus of the mandible and the mastoid process on each side.

Each transverse process should be located at the center of this crotch from superior to inferior, and posterior to anterior. Placing the tips of the third finger on each transverse process, facing the patient from the rear, would develop the fact of neither side being more prominent, laterally, than its opposite.

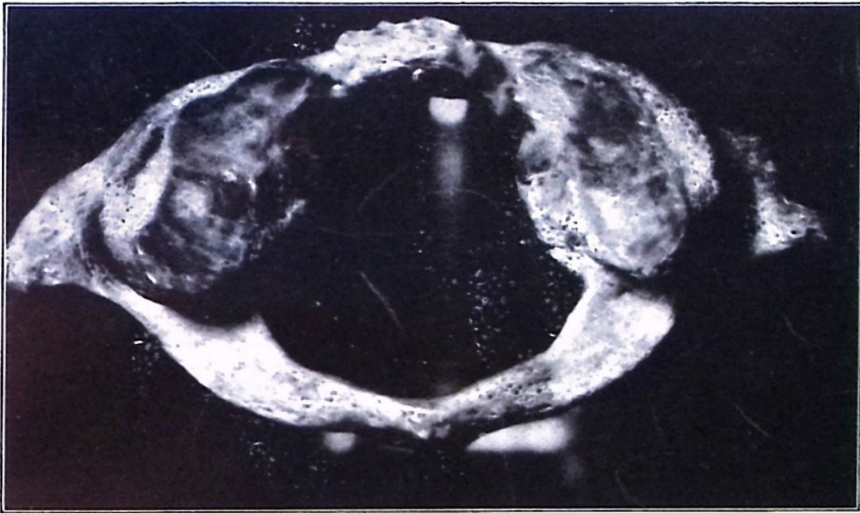


Fig. 28. Enlarged view of specimen which shows great variation in transverse processes.

It occasionally happens that the transverse processes vary in shape, (Fig. 28) breadth or length from the normal median or horizontal lines. This may be due to fractures, direct injuries, osteomalacia, other diseases, or lack of development in foetal or the expanding age. The product is an abnormal configuration so that lateral palpation is a difficult matter. The atlas has no spinous process or other means of locating its position than the above. The next best diagnostic feature is the natural posture of the head when under surveillance.





Fig. 29. Head leaning to *right and forward.*



Fig. 30. Head leaning to *left and forward.*



Fig. 31. Head leaning to *the right.*



Fig. 32. Head leaning to *the left.*



Fig. 33. Head bent to the *anterior*.



Fig. 34. Head flexed to the *posterior*.



Fig. 35. Head flexed to *posterior and left*.



Fig. 36. Head flexed to *posterior and right*.



If it flexes to the right and forward, (Fig. 29) it has a subluxation that is left superior and anterior. If left and forward, (Fig. 30) the subluxation is right, superior and anterior. If to the right, (Fig. 31) it would be superior left. If to the left, (Fig. 32) it would be superior right. If anterior, (Fig. 33) it would be superior. If to the rear,

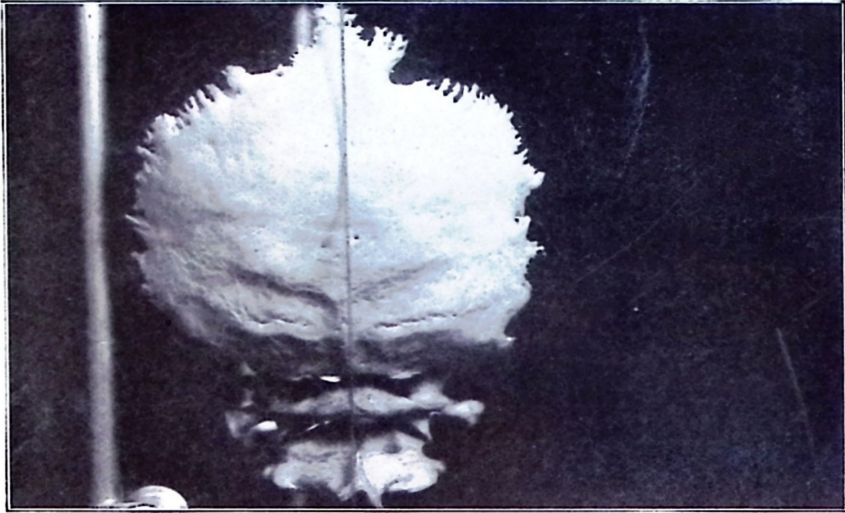


Fig. 37. *Posterior* of occiput, atlas and axis. Normal.

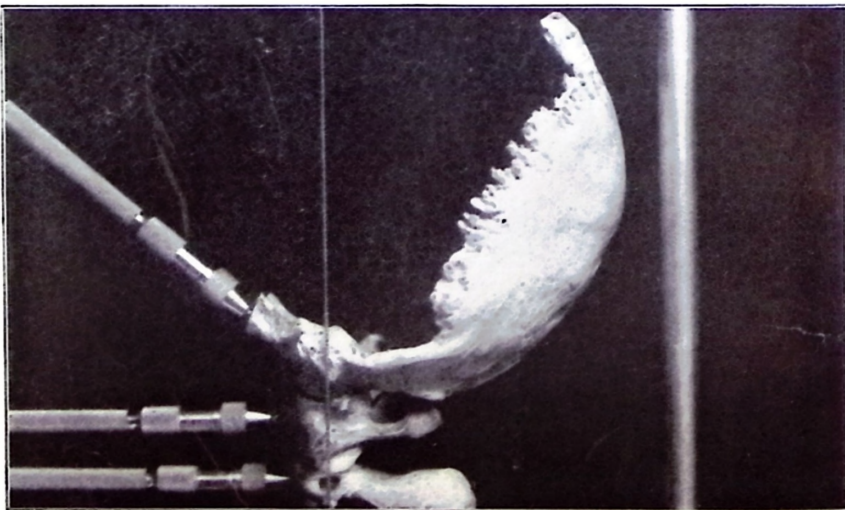


Fig. 38. *Lateral* view of occiput, atlas and axis. Normal.

(Fig. 34) it would be inferior. If backward and to the left, (Fig. 35) it would be left, superior and posterior. If right and backward, (Fig. 36) it would be right, superior, and posterior.

The above is exemplified when you recognize Mr. or Mrs. Blank by the position and manner in which thou carries the head in some abnormal position. Even tho your view be a posterior one it proves the existence of a subluxation the more certainly.

Certain swinging positions and motions of the head and body characterize your friends or relatives, the abnormalities of which depend upon subluxations for their continued existence. Inquiry might not reveal thons knowledge of such, yet the Chiropractor will reveal it every time. Close observation of the actions of any or all of your patients will enlarge your scope upon this vital subject and prove that after all, observation and knowledge of the difference between the normal and abnormal gaits and movements are a great advertiser of the conditions and contours of the spine even tho the one observed be a stranger.

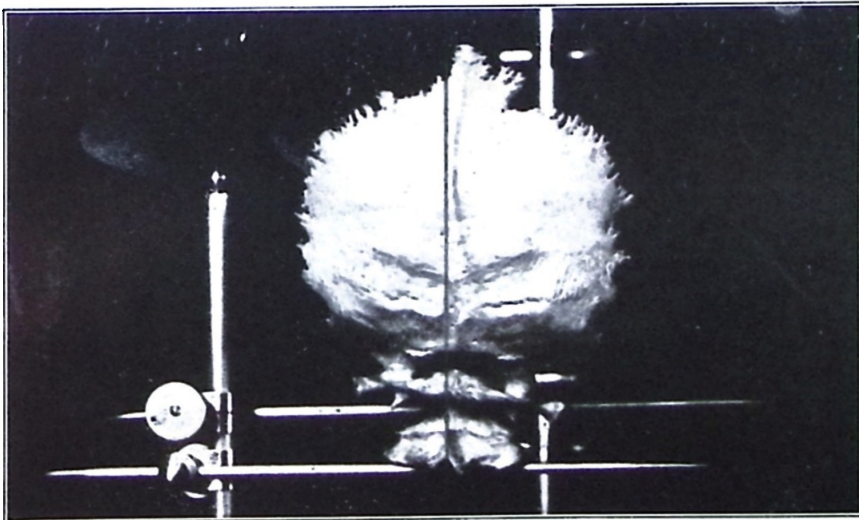


Fig. 39. Left superior, or right inferior subluxation. Both sides are equidistant from the perpendicular median line. The head would tip to right, and if the subluxation be anterior or posterior, the slant would be according.



### 3. *Normal position and articulations.*

The articulations are 5 in number, 2 superior, 2 inferior, and 1 articular facet for the anterior facet of the odontoid.

It articulates superiorly with the condylar facets of the occipital and, inferiorly with the superior articular facets of the axis, anteriorly with the anterior articular facet of the odontoid process.

Upon the under surfaces the articular facets are circular and slightly concave, being directed downward and inward, so that they enable the atlas to rotate readily upon the axis vertebra below. Below the inner border of each superior articular process there is a small tubercle for the attachment of the transverse ligament, which divides the ring of the atlas into two unequal parts, the anterior receiving the odontoid process of the axis, and the posterior being occupied by the spinal cord containing all the nerves as they pass externally from the brain. The costo-transverse processes extend farther than those of any of the other cervical vertebrae for the attachment of muscles

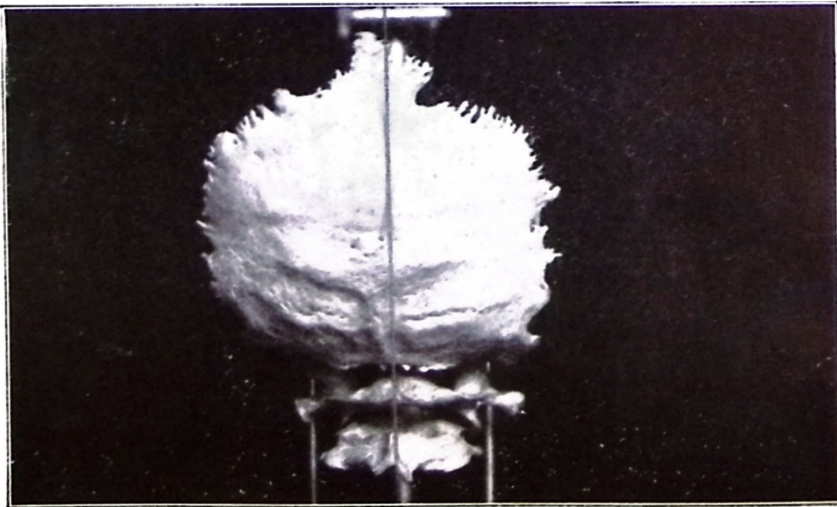


Fig. 40. Right subluxation. The perpendicular rods show the right transverse process too far to the right of the median line. The skull would appear unset upon its base.

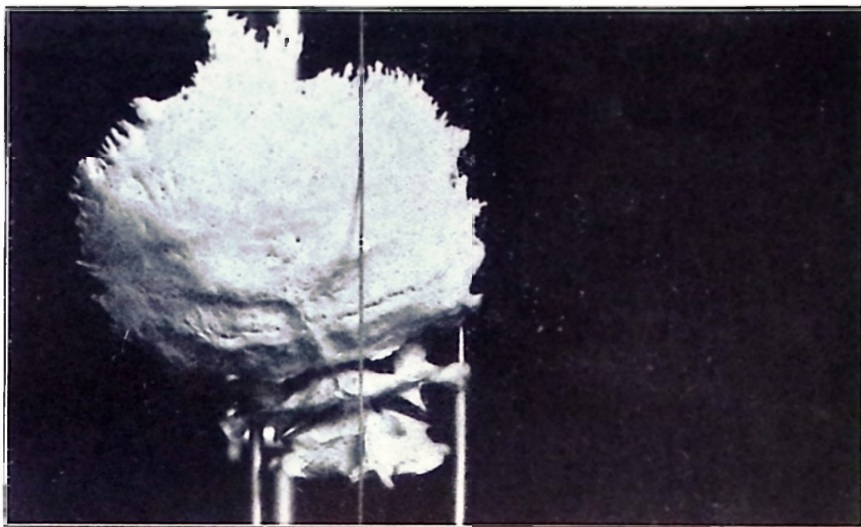


Fig. 41. Left inferior subluxation. Notice that the transverse is to the left of median line as is also the posterior tubercle of the posterior arch of the atlas. The head would be to the left and drooping laterally.

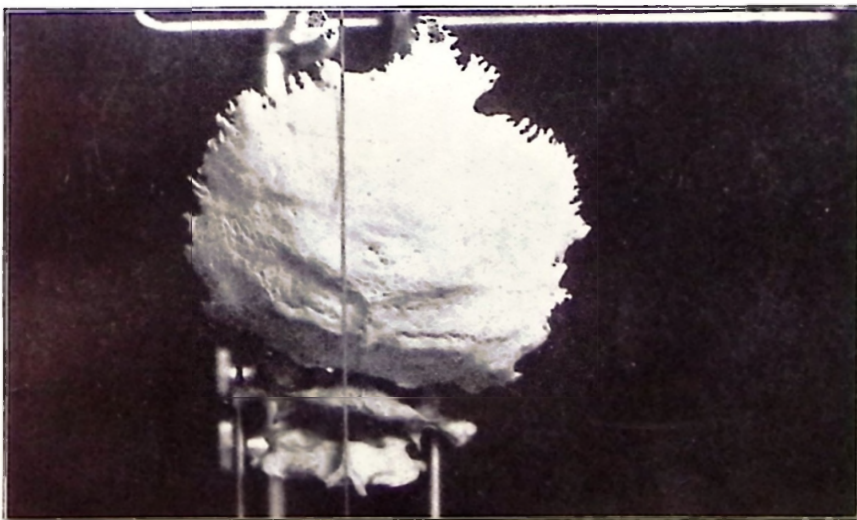


Fig. 42. Right inferior subluxation. Close study of the illustration proves its position. This might exist with the combination of 39, 40 or 41 and would add the drawing of the head and neck posteriorly upon the shoulder.

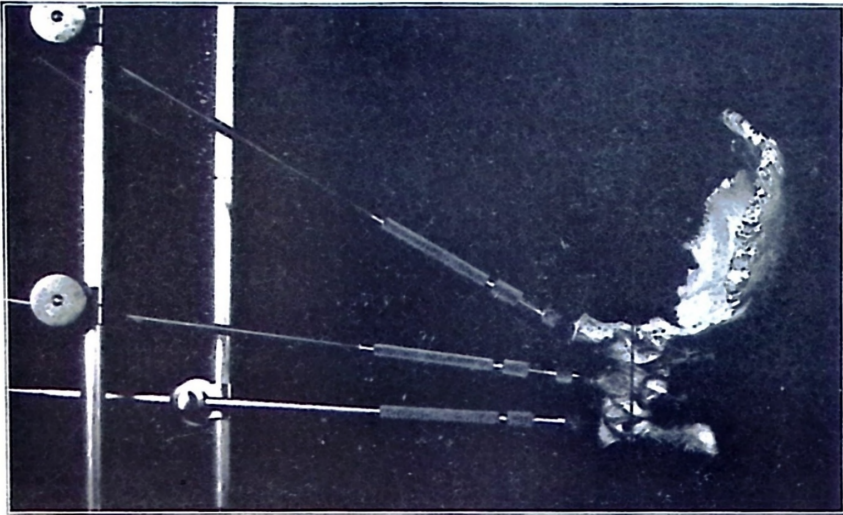


Fig. 43. Left lateral view. Posterior subluxation, which might exist with any one or more of the combination of Fig. 39, 40, 41, or 42, and would tend to show that side of the head and neck superior and the other side inferior upon the chest.

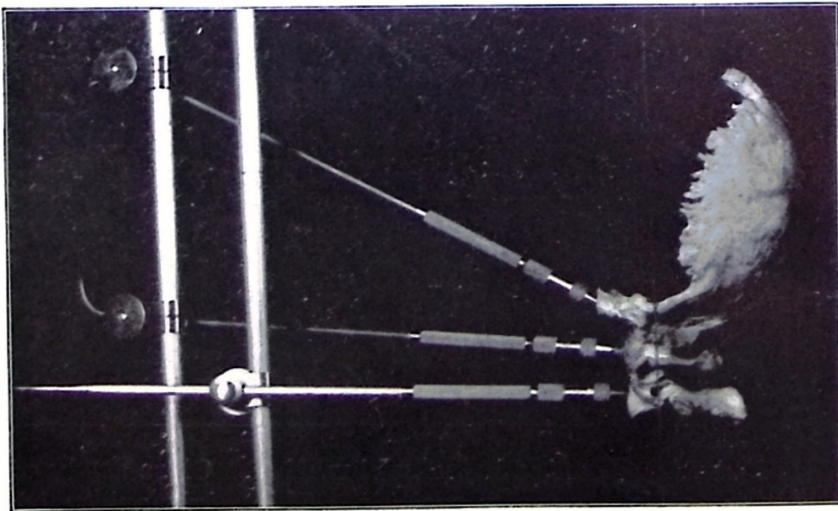


Fig. 44. Left lateral view. The opposite of Fig. 43, and would involve similar conditions in opposite directions.



which assist in rotating the head. Thru the foramina in these processes the vertebral arteries ascend, and turning backward and inward, are accommodated upon grooves behind the lateral masses, which also transmit outward

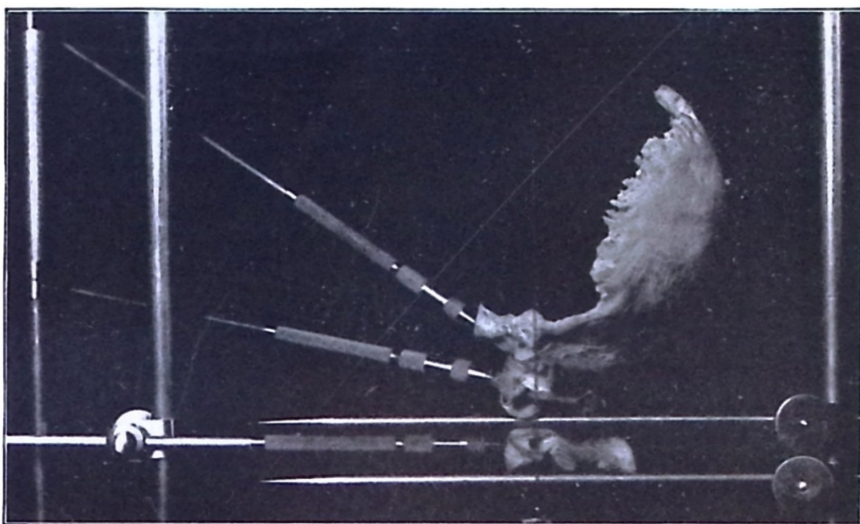


Fig. 45. Left lateral view. Superior anterior subluxation.

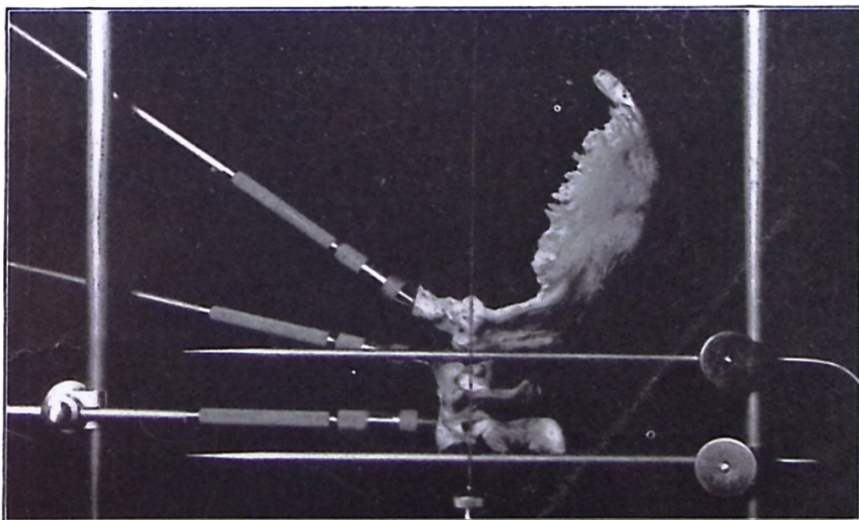


Fig. 46. Inferior anterior subluxation. The student must examine the median as well as the horizontal lines to bring out these differences.



the first pair of *brain* nerves. These grooves are sometimes converted into foramina by the development of bony spiculae arching across their borders.

4. *Subluxations described and illustrated.*

Subluxations of atlas, considering from position of

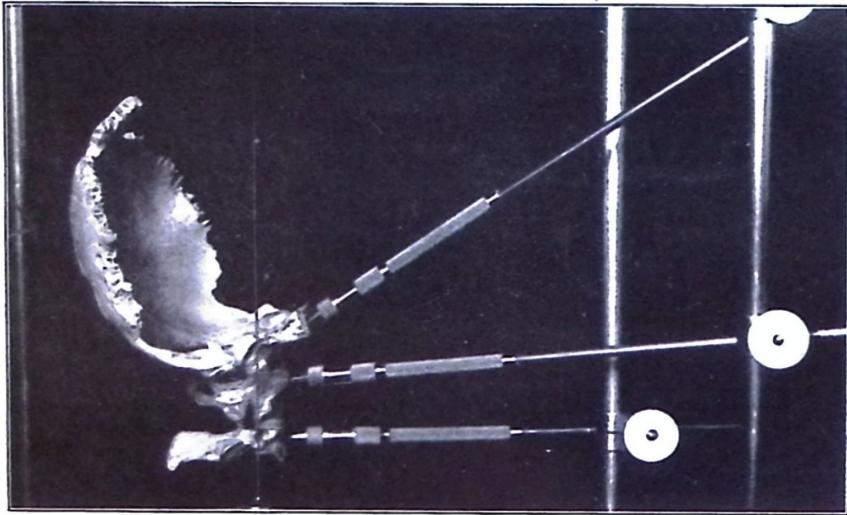


Fig. 47. Right lateral view. Posterior subluxation. Study the position of the transverse process compared with the plumb line.

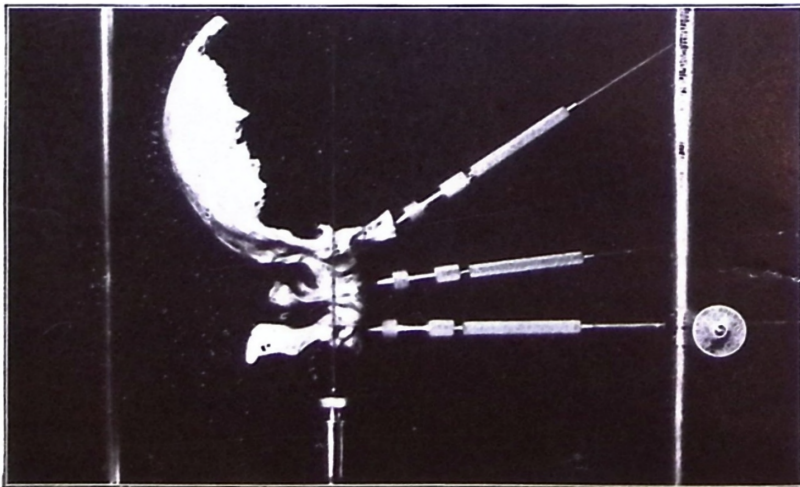


Fig. 48. Right lateral view. Anterior subluxation. The opposite of Fig. 47.

transverse processes would be anterior or posterior; superior or inferior; or to the left or right, or any combination of these.

6. *Where Nerves are impinged.*

In normal position there will be no pressure between

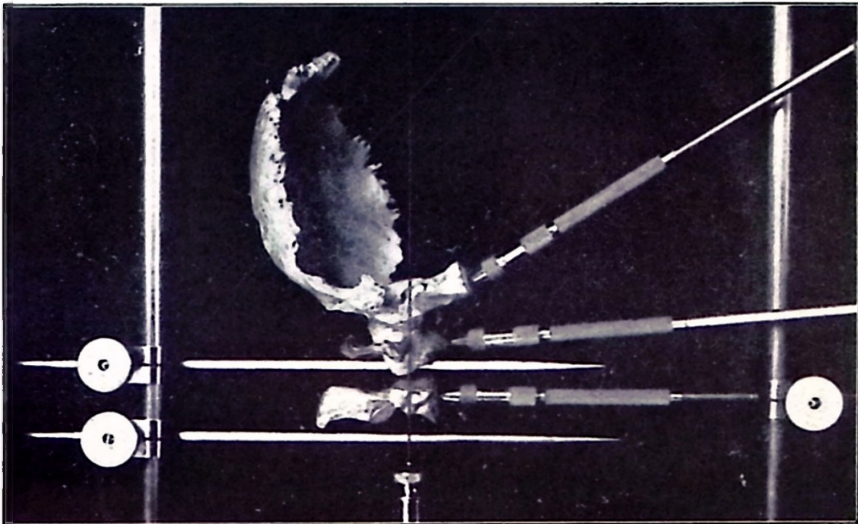


Fig. 49. Right lateral view. Superior posterior subluxation.

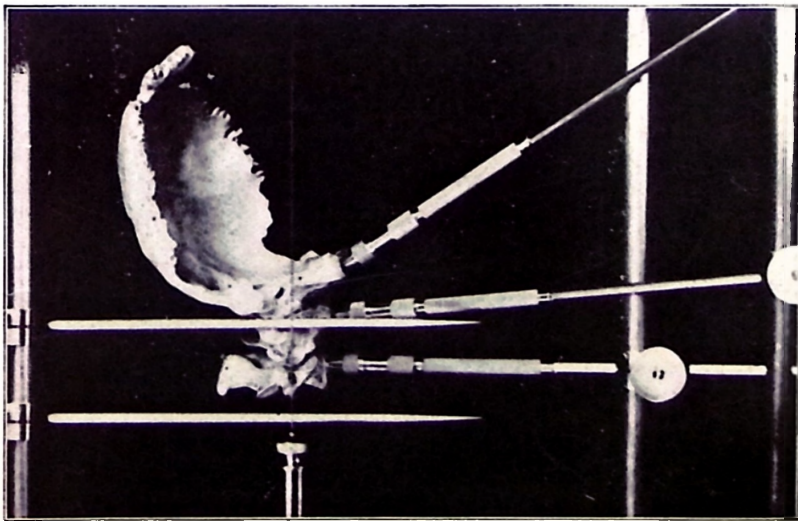


Fig. 50. Right lateral view. Inferior, posterior subluxation.

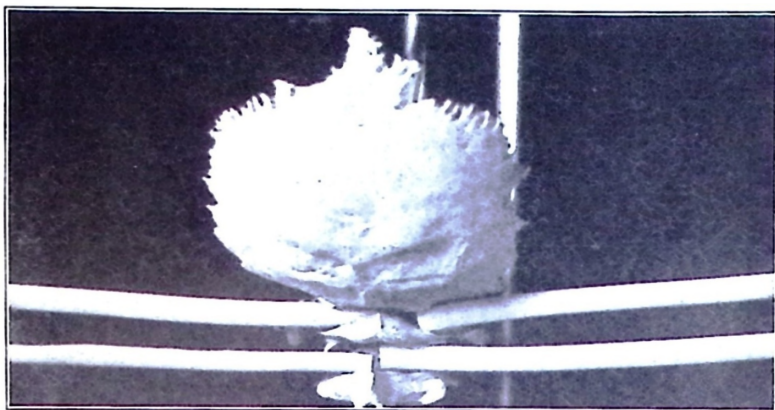


Fig. 51

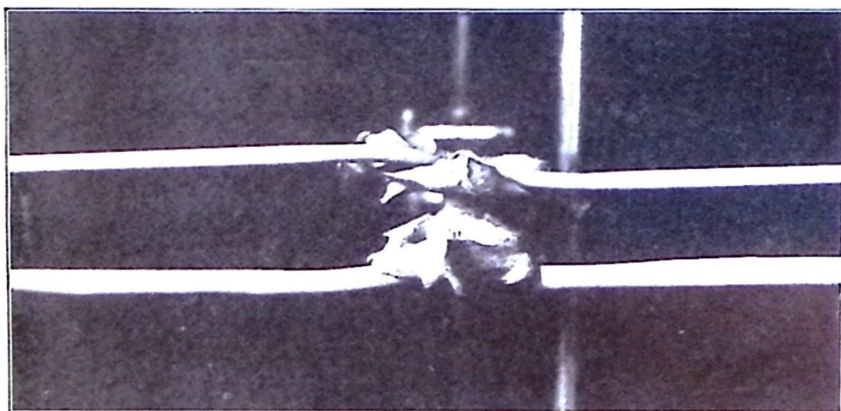


Fig. 52

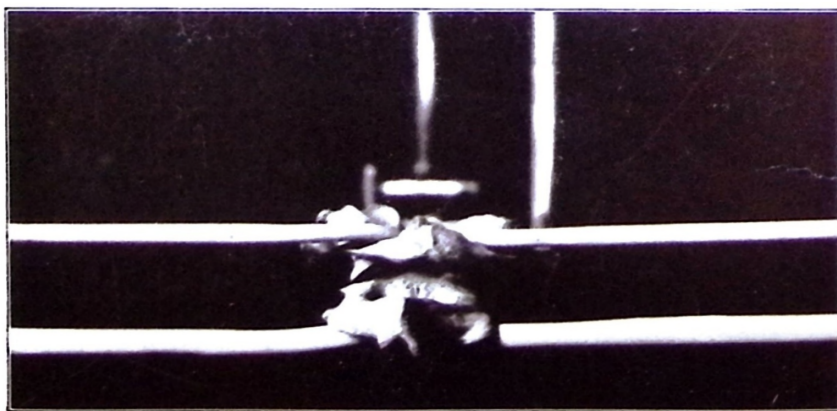


Fig. 53





Fig. 54

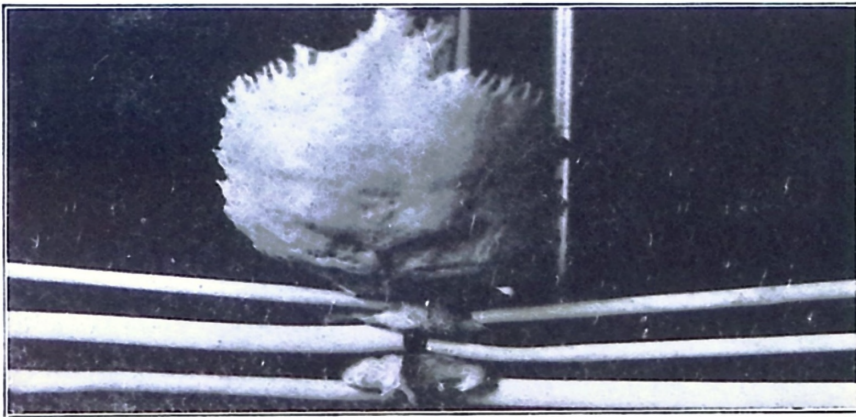


Fig. 55

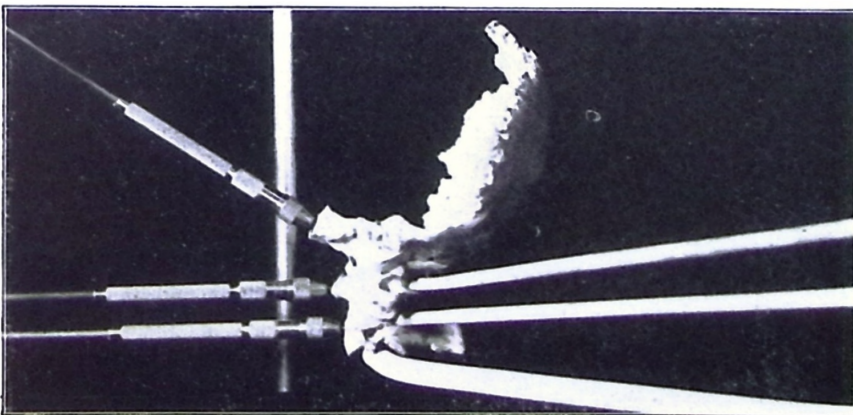


Fig. 56



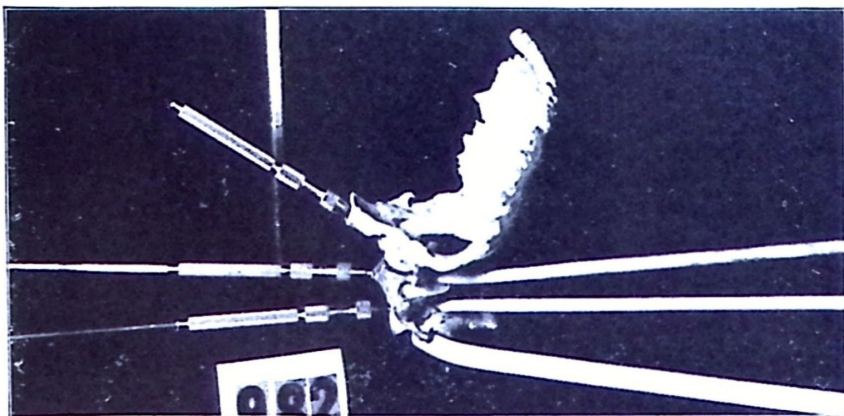


Fig. 57

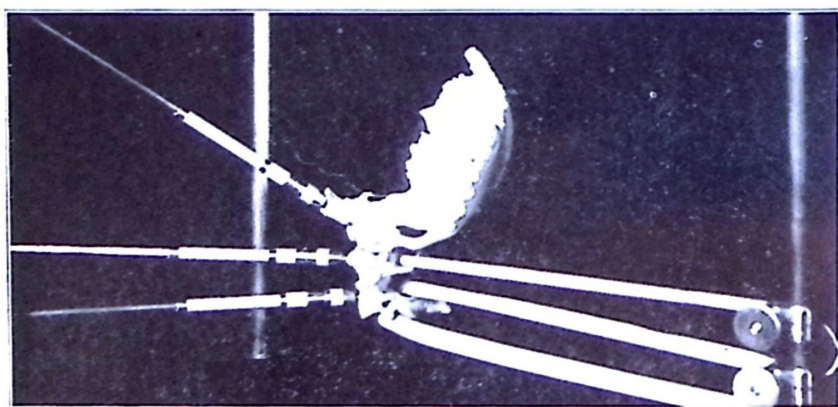


Fig. 58

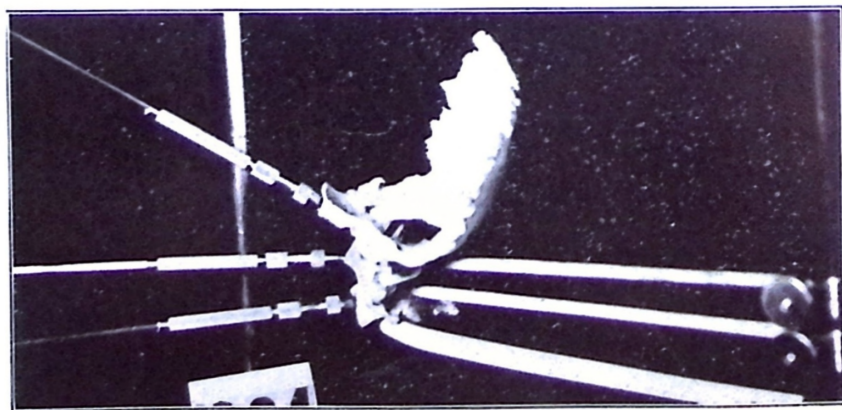


Fig. 59

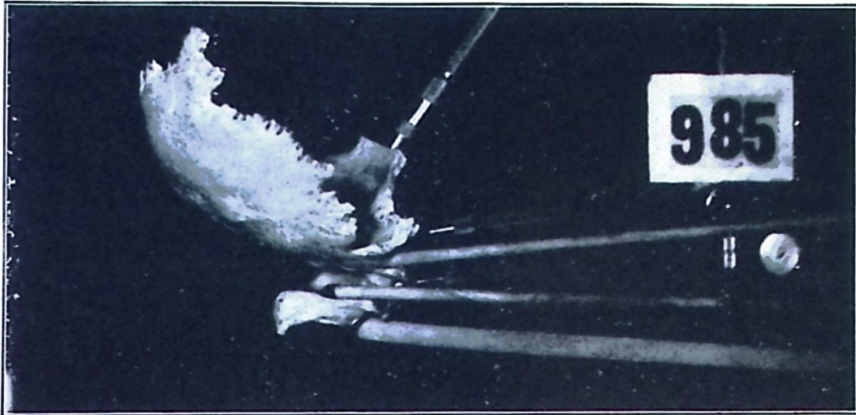


Fig. 60

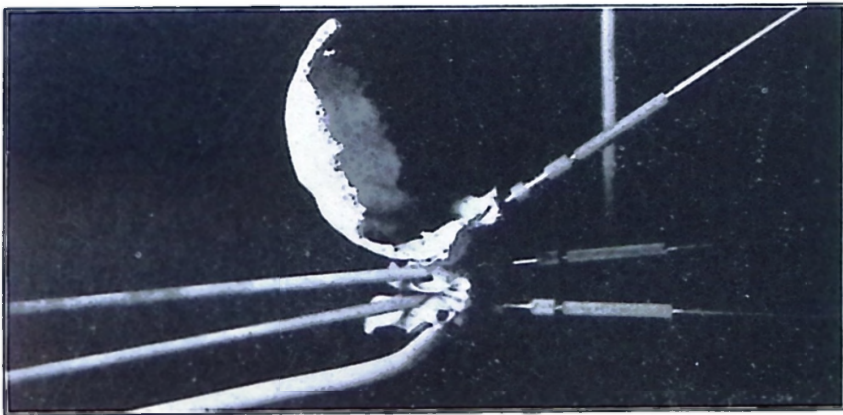


Fig. 61

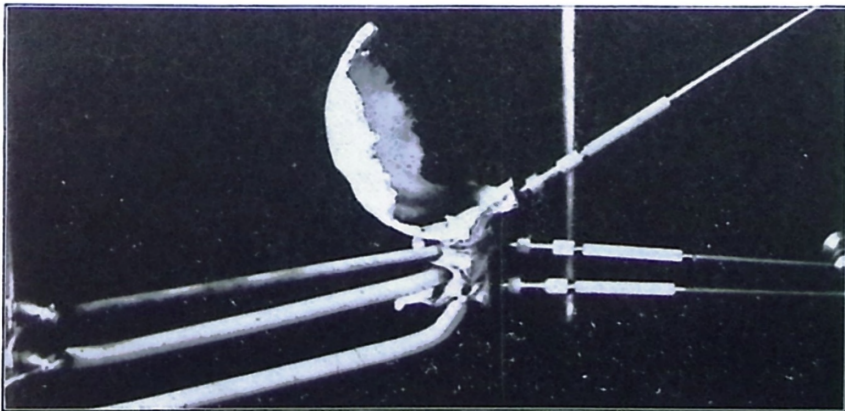


Fig. 62

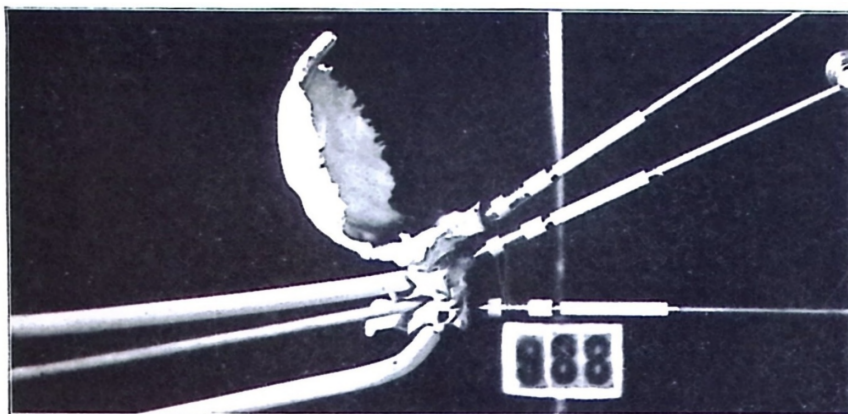


Fig. 63

Fig. 51. Four large nerves in foramina. Vertebrae normal in position.

Fig. 52. *Left superior or right inferior* subluxation, showing pressures upon nerves emitting at left superior and right inferior foramina.

Fig. 53. *Right* subluxation showing pressures upon both sides of superior of atlas.

Fig. 54. *Left inferior* subluxation showing pressures upon left superior and inferior and upon right superior of atlas.

Fig. 55. *Right inferior* subluxation, showing pressure on left superior, right superior, and right inferior of atlas.

Fig. 56. Subluxation is *posterior* of left transverse process. Pressures are upon superior and inferior of atlas.

Fig. 57. Subluxation is *anterior* of left transverse process. Pressures the same as in Fig. 46.

Fig. 58. *Superior and anterior* subluxation of left transverse process. Pressures the same as in Figs. 46, 47.

Fig. 59. *Inferior and anterior* subluxation of left transverse process. Pressures identical at Figs. 46, 47 and 48.

Fig. 60. *Posterior* subluxation of right transverse process. Pressure upon superior and inferior of atlas on right side.

Fig. 61. *Anterior* subluxation of right transverse. Pressure same as Fig. 60.



Fig. 62. *Superior posterior* subluxation of right transverse. Pressure upon superior of atlas.

Fig. 63. *Inferior posterior* subluxation of right transverse. Pressure upon inferior of atlas.

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superior notches and inferior of occipital. Any subluxation which tends to crowd these two surfaces together, or put these nerves upon a tension by bony displacement, would occasion pressure.

If through subluxation the right or left transverse be prominent on either side, it would make pressure upon those nerves *encircling the notch* on that side; and vice-versa.

If either transverse be prominent to anterior or posterior the same results would be manifest, because of the same conditions.

The inferior notches also permit the exit of the second pair of brain nerves, therefore are subject to pressures upon one side or both; the same as is noticeable on the superior.

#### 7. *How and What makes Pressures.*

Tightness of nerves produced by and pressure then created upon one of more sides by bone makes the same abnormal functions as and is equivalent to entire pressure, and is a constricting force modified. A superior subluxation of atlas, determined by palpation of either or both transverses, would make compression between that notch and the occipital of frequent occurrence. If the right has this condition, the left side usually shows the opposite, although both sides are easily palpated and might be found with pressure, therefore tender. The side most prominent would have more pressure as a general rule. Occasionally where the one transverse process is superiorly prominent, the opposite inferior will be the greatest point of pressure upon the second pair of nerves. *There is no set rule for this but it must be made specific in each case by digital palpation and nerve tracing.*

#### 8. *Functions and Organs involved. Location of—*

According to extended experience the nerves emanat-



ing from the superior of Atlas, convey mental power to express *all* the functions of and in the brain; in the majority of cases controlling the functions of hearing as far as concerns acousticity; the repairing of cranial fractures; a large majority of the nerves found terminating in brain and skull, enter from the spinal cord at this point.

9. *Adjustments necessary to correct each.*

Each subluxation of the Atlas must be analyzed according to its abnormal position; the adjustment, in general, depending upon the correction of the same to a median line both horizontally and perpendicularly. I know of no other vertebra requiring such exact skill to accomplish the right results.

To adjust the left superior or right inferior subluxation (Fig. 64), force must be so directed as to throw atlas to right or left and also inferior or superior from or toward the skull. The direction of this simultaneous movement being inferior or superior, to the right or left.

Right subluxation. (Fig. 65). The movement would be directed on right transverse and to the left.

Left inferior subluxation. (Fig. 66). Adjusting force should be left upon left transverse given obliquely superior and to the right, thus returning the left superior condition to normal.

Right inferior subluxation. (Fig. 67). Further combinations of these might be met with as to whether the transverse be anterior or posterior as is illustrated in Figs. 64, 65, 66, 67 and 68.

Posterior subluxation of left transverse. (Fig. 68). The adjustment would be anterior, and in any other direction according to combination.

Anterior subluxation of left transverse. (Fig. 69). The opposite of Fig. 68 would be posterior, and in any other direction according to combination.

Superior anterior subluxation of left transverse. (Fig. 70). The adjustment would be inferior and posterior.

Inferior anterior subluxation of left transverse. (Fig. 71). The direction for this adjustment would be superior posterior.

Posterior subluxation of left transverse. (Fig. 72). This adjustment would be given on the right transverse process in an anterior direction.

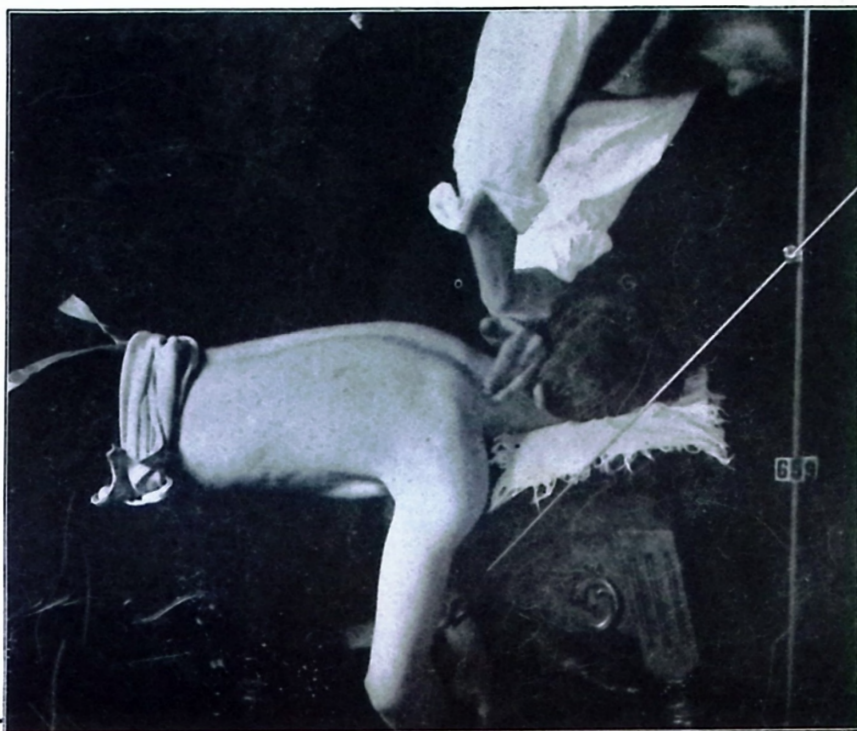


Fig. 64.



Fig. 65.

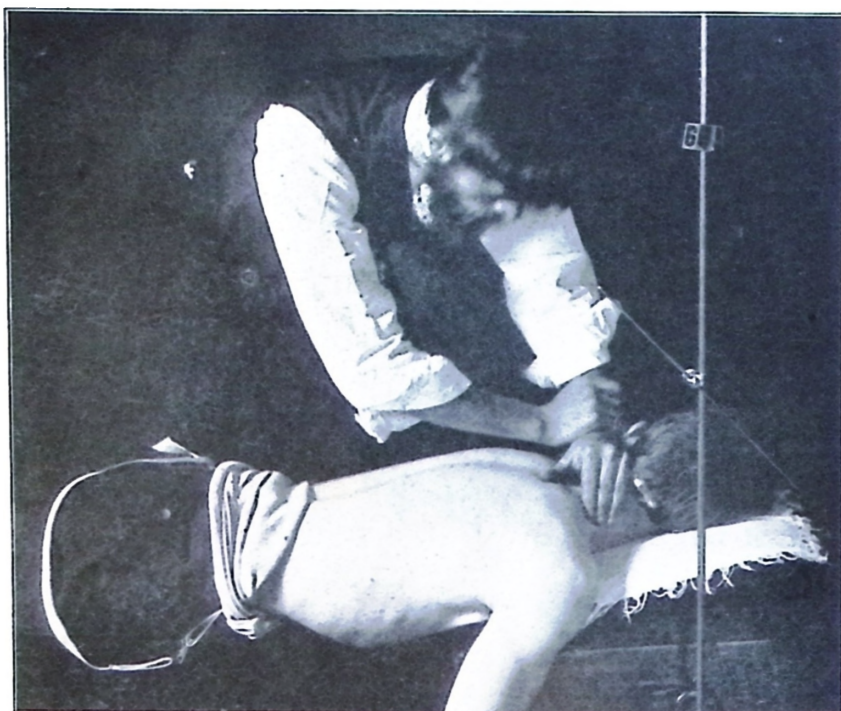


Fig. 66.



Fig. 67.



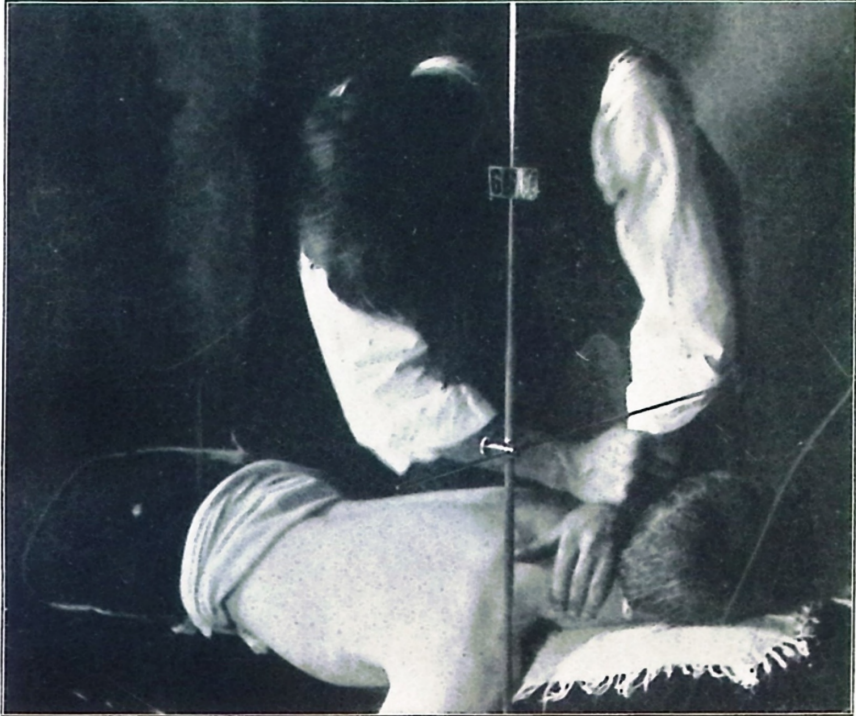


Fig. 68.



Fig. 69.



Fig. 70.



Fig. 71.





Fig. 72.



Fig. 73.



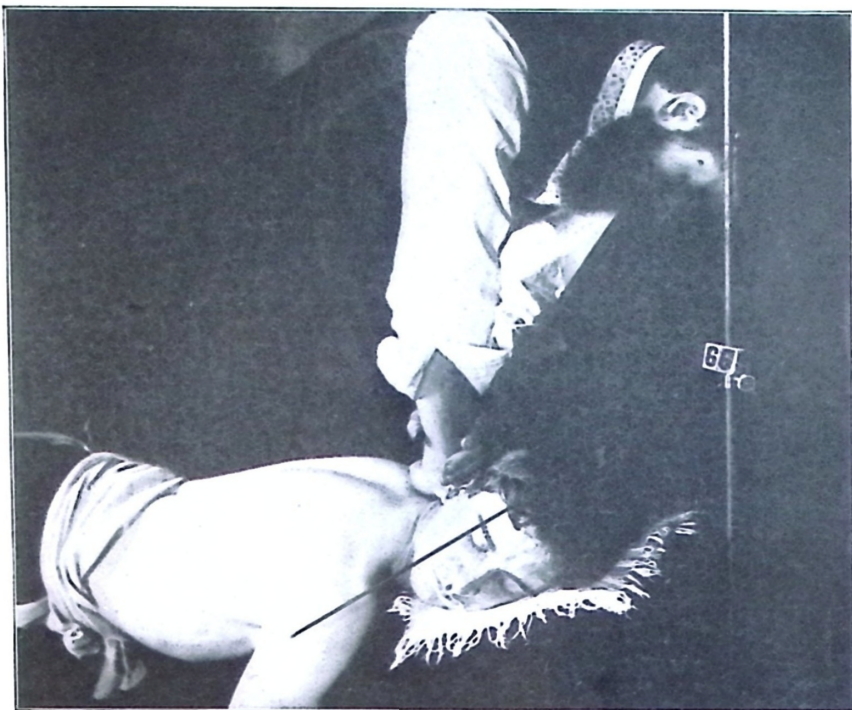


Fig. 74.



Fig. 75.

Anterior subluxation of right transverse. (Fig. 73). The anterior subluxation is adjusted upon the same process in the opposite direction, hence posterior. This is the opposite of Fig. 72.

Superior posterior subluxation of right transverse. (Fig. 74). The superior, posterior subluxation is adjusted inferior anterior.

Inferior posterior subluxation of right transverse. (Fig. 75). The inferior, posterior subluxation is adjusted superior anterior.

10. *How to give adjustments correctly.*

All adjustments are based around the principle of a hammer and nail driving illustration. Carpenters place the board and determine to what direction the nail must be driven to effect and perform the service required.

After palpating, the position of the atlas has been estimated, the direction *in which to adjust* has been considered, and in *what direction* to apply the force must be definitely understood. A nail has three essentials, viz:—the head, shaft, and point. The junction of thumb with wrist, superior portion, is equivalent to the nail head, just anterior to the pisiform bone of the hand of the same hand is similar to nail point, a diametrical line between these two points is your nail shaft. This illustration refers to the nail which you make of the hand which is in contact with the patient's body, therefore the thing driven.

11. *What means, and portions thereof, to use.*

A very easy and effective adjustment is what is known as the "T. M.", Thumb Move. The thumb is placed over,, under, to one side, or on, the spinous or transverse process to be adjusted. The head is then directed to the opposite of that direction in which you desire to give the adjustment. This movement is very effective but extremely dangerous. Its application should never be used unless under the direction of a competent teacher to correct any wrongs committed should there be such. Very little force is needed upon the part of the adjustor. The head is drawn way back or to the side, and then when almost to its limit, give it a quick jerk farther backward, at the same

time giving a decided emphatic adjustment with the thumb which has remained firm upon the process. Till 1899 this was the only means used at *The P. S. C.* for adjusting cervicals. In these, patient remains sitting. It is adaptable to almost any location and can be used readily if the patient is so placed that he does not care to undress. (See Axis adjustments.)

In driving a nail, the impetus is given with the hammer while the nail remains firmly placed and just where it must enter. So, with the nail hand, it remains firmly



Fig. 76. Nail, hammer and board. Hammer is up-raised ready to give nail an adjustic movement. The right way to do.



Fig. 77. Hands clasped around hammer which is on nail ready to "thrust" the nail into the board. The wrong way to give an adjustic movement.



placed in contact with the vertebra to be adjusted.

The hammer is a thing separate from the nail, but the opposite hand of the adjuster is to him what the hammer is to the nail. From it approximately two-thirds of the power necessary to give an adjustment is derived, the remaining one-third, having its source in the hand which acts as the nail.

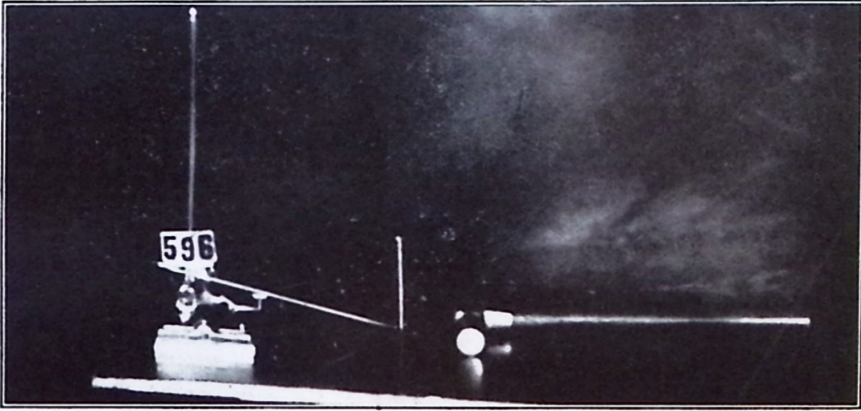


Fig. 78. Pointer indicates nail point of nail.

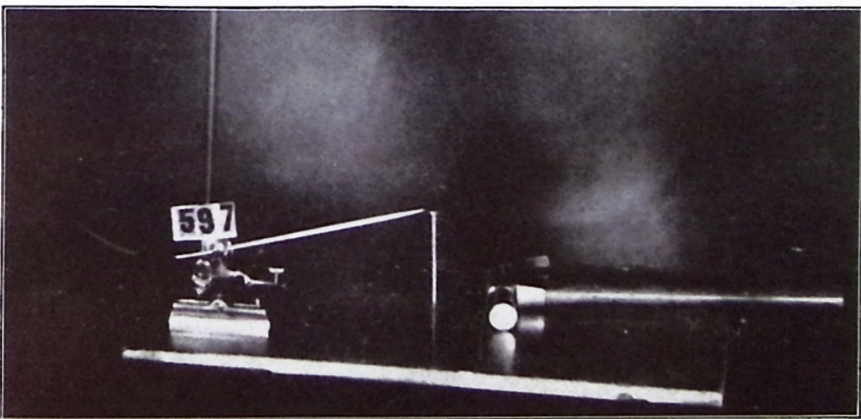


Fig. 79. Pointer indicates nail head of nail.

The *hammer* must raise and lower apart from the nail, to derive sufficient force to give that quick, metallic, springing, rebounding, impetus necessary to drive inward the nail. Any amount of pushing of the hammer, in direct contact with the nail would be very ineffective. A light hammer with a heavy nail, with that quick, one second.

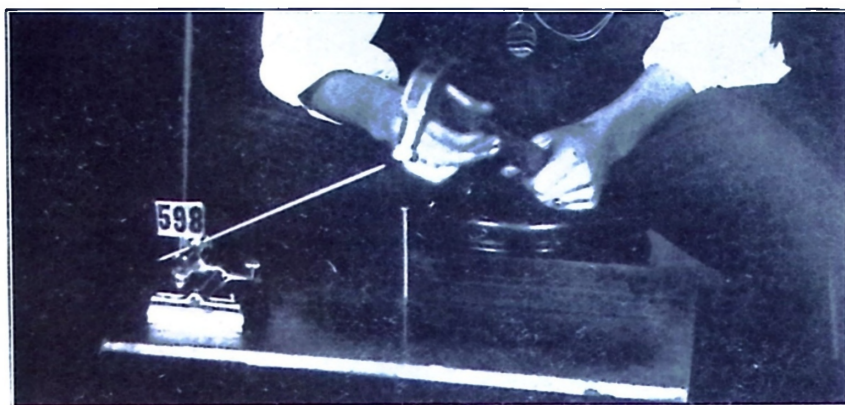


Fig. 80

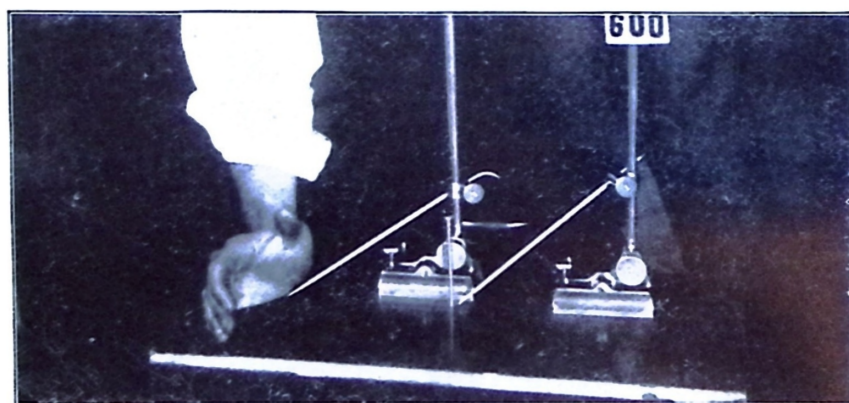


Fig. 81



Fig. 82

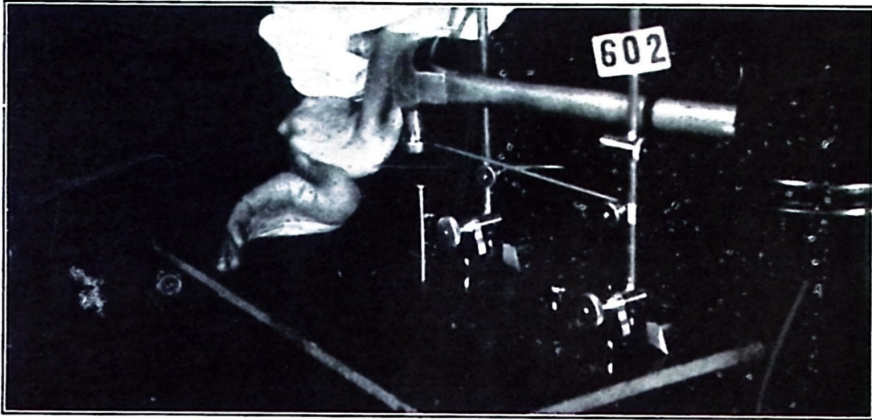


Fig. 83

Fig. 80. Pointer shows hammer head of hammer up-raised and ready to give that movement which all mechanics know will put the nail where desired.

Fig. 81. Pointers bring out nail point of nail and by comparison show nail point of hand.

Fig. 82. Pointers show nail head of hand and nail by comparison.

Fig. 83. Pointers show hammer head of hand firmly and properly placed over nail head of opposite hand. The same is true of hammer head of hammer which is raised over nail head of nail.

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piano or typewriter touch will drive it deeper than 100 lb. push could do in an hour.

The hands must proceed in like manner. The nail must have a head, a shaft and a point. The superior hand, working like a hammer, has its head in the same place that the inferior hand has its nail point. The hammer head of the one hand must be placed on top of the nail head of the opposite, and the two firmly held together, both resting lightly upon the patient's vertebra, then with that famous Chiropractic, one second adjustment, the vertebra has assumed its normal position in acute cases or partially so in corresponding chronics.

The force in all adjustments is derived from the entire arms and shoulders. To make adjustments effective they must be given in that manner that you would use in driv-



ing a nail. The adjustment of the Atlas is by far the most delicate and requires the best talent and careful work upon the part of the adjuster.

Careful study shows it to be in a peculiar position, especially when the patient lies upon the bench with his head lying laterally.

The adjuster stands upon one side or the other, usually, if he deems it best, to adjust the least prominent side first, the object being to loosen the joint then reverses and adjusts that which is more noticeable to return to normal position. A deviation is made in the manner of exactly locating the lamina in cases of patients prone.

Locate the spinous process of the Axis and Transverse process of the Atlas, bisect this space and the center point, close to the skull will prove that underneath is the junction line of the lateral and posterior portions of the lamina of the Atlas. (See Figs. 26-27).

The peculiar position of the adjusting of laminae, makes it an object to shift, on our nail hand, the point of the nail *to the center of the fifth carpal bone*, which is placed in direct contact over the place previously palpated.

In adjusting the transverse process, the heel or nail point can be used quite effectively, providing the hand and forearm be crotched into that place, but I prefer the first position, viz.;—closing the hand and placing the corner made by the articulation of the fifth metacarpal with the phalanges, this being placed upon the transverse is very effective from which Atlas can be adjusted in any of the six directions upon which are based all movements.

In this position the nail head is the superior portion of the hand, the opposite or hammer hand being placed in appropriate position thereto so that the *quick, combined movement of both, allows all force to be focalized on that spot* which is in direct contact with the process of the vertebra being adjusted.

## 12. *What Diseases to Adjust the Atlas For.*

Insanity, "mental diseases," conditions which are in-

terpreted as sharp shooting pains, commonly known as "Neuralgia of the Head," wryneck, torticollis or torticollis spastica, cranio-malacia, eburnation, craniotabes, idiocy, epilepsy, apoplexy, and as a combination with hydrocephalus, or its opposite where the skull or brain lacks its normal supply of serum or urea, osteosarcoma, bone tumor, caries and necrosis, ulcers, boils and gatherings, ringing or buzzing in ears, head noises, some forms of deafness, cerebralmenengitis, catalepsy, excessive heat in brain, or the lack or excess of any one of the 7 primary functions in the skull or brain.

## CHAPTER 5.

## AXIS.

1. *Vertebra and Its Title. Ax. P.*

The second cervical vertebra is called the axis, because it serves as a pivot upon which the head rotates. It

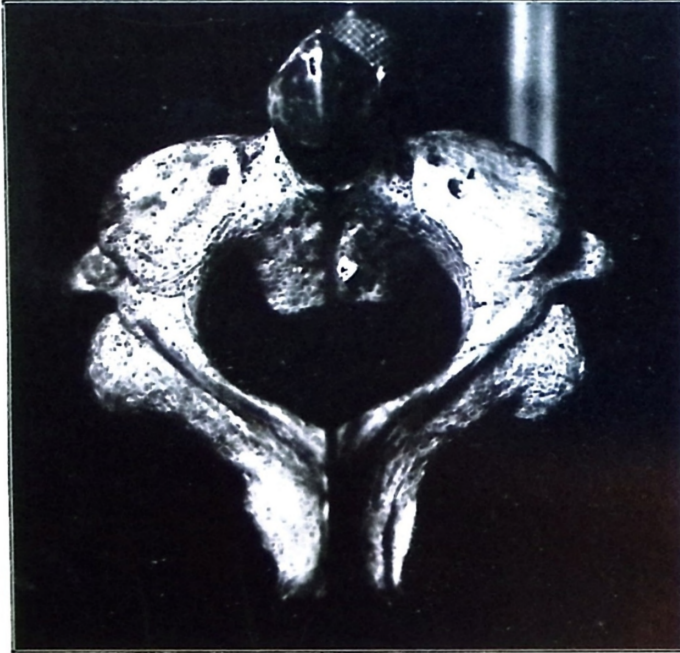


Fig. 84.

is the strongest of the cervical vertebrae and its most distinctive feature is the odontoid process, which is supposed to be the detached body of the atlas, but in osseous development is independent. The pedicles, laminae, and spinous processes are remarkably strong; the latter presents a median superior ridge with short, depressed lateral tubercles. The articular surfaces are modified to adapt them to the surfaces of the vertebrae with which they are in contact, and the costo-transverse processes are shorter and the vertebral foramina smaller than in the atlas.

The process on the posterior arch of this vertebra is prominently bifurcated. Its prominence and proximity to the skull makes it an easy-mark for direct blows which fre-



quently fracture one prong or the other or sometimes both.

Try to determine these facts before proceeding.

2. *Superficial Palpation and Landmarks.*

Owing to Axis having no prominent transverse pro-



Fig. 85. Head with face downward, patient prone, showing approximate position of axis and how to place fingers to find it.



Fig. 86. Head flexed backward showing how to locate axis with patient prone.



Fig. 87



Fig. 88

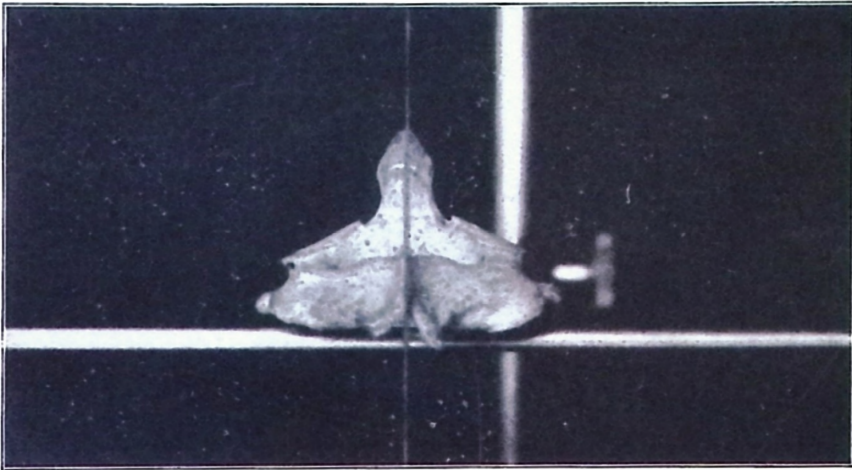


Fig. 89

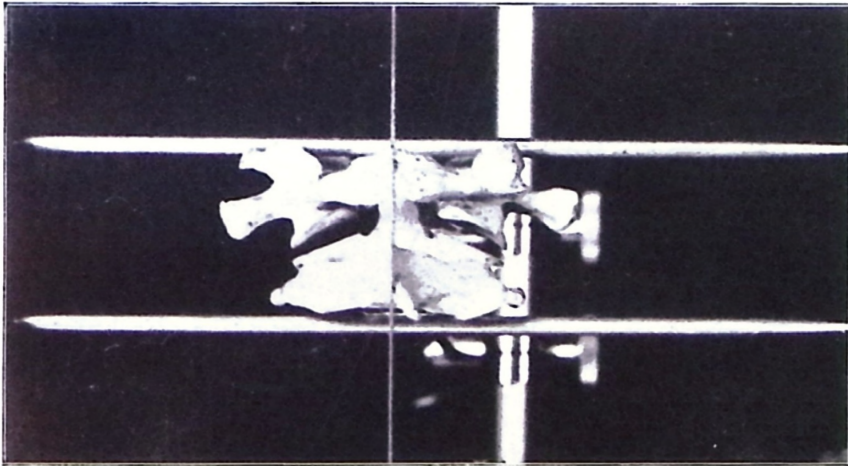


Fig. 90

Fig. 87. Shows how to palpate with patient sitting with head forward. *Always use three fingers.*

Fig. 88. Head thrown backward allowing axis spinous process to drop into median groove on inferior of occiput.

Fig. 89. *Posterior* view of axis showing median and horizontal lines.

Fig. 90. *Posterior* view of atlas and axis. Normal.

Fig. 91. *Left lateral* view of atlas and axis. Normal.



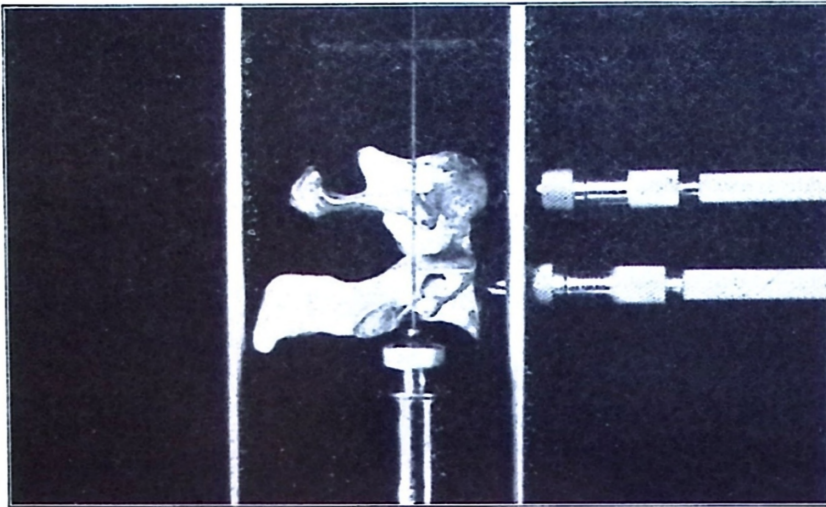


Fig. 91

cesses and in such close proximity to the Atlas it has only one prominent palpating surface—the spinous process. At the base of the occipital is easily felt this process, which is the first one observable. With the neck flexed posteriorly and inferiorly, the spinous process should fit, medianly in the groove upon the occipital. This is the best analytic position to determine the exact position of Axis.

### 3. *Normal position and articulations.*

Its normal position is to be square with a perpendicular line drawn through the odontoid superiorly and the centrum inferiorly and with a horizontal line through the centrum laterally. It has seven articular surfaces, two prezygapophyses, two post-zygapophyses, one anterior, one posterior, one on odontoid, and one on inferior of centrum. The prezygapophyses articulate with the postzygapophyses of Atlas.

The postzygapophyses articulate with the superior articular surfaces of third cervical. The anterior facet of odontoid articulates with the surface for that purpose on posterior of anterior arch of Atlas.

The posterior odontoid articular surface articulates with the transverse ligament. The inferior of centrum articulates with the superior of the body below.

#### 4. *Sub-luxations, described and illustrated.*

In the majority of cases where Axis is subluxated it can be generally proven whether it is the Atlas or Axis or both by comparison, Palpation of the transverse of Atlas and spinous of Axis will prove this a fact in 90 percent of such supposed conditions. Examination of the Axis spinous process will often show it to be left or right of the median line. Broad experience has proven that adjustment of this with an object of returning it to a median line from any obnormal position has accomplished splendid results. The only case of serious injury on record at *The P. S. C.* was one wrongly adjusted on Axis in which the patient turned black and gasped, what seemed to be her last breaths. Immediate action was taken in returning that vertebra to where it formerly was. Subsequent adjusting corrected the causes of the troubles which she had. If ways and means were demonstrable, it is my opinion that adjustments, which are given to Axis in the majority of cases, aim but to place the Atlas easier and quicker.

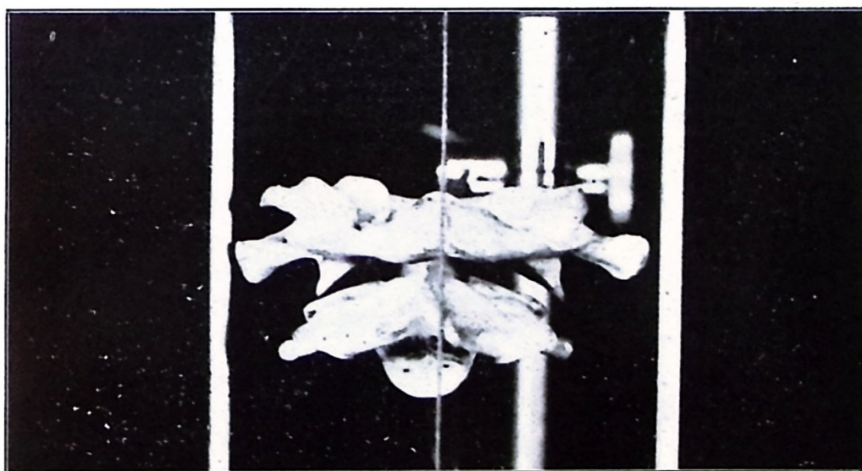


Fig. 92. Left superior sub-luxation. Detail shows spinous process of axis is to left of median line and closely crowding the posterior arch of atlas.

Fig. 93. Plain left sub-luxation of the axis.

Fig. 94. The opposite of Fig. 93.—right sub-luxation.

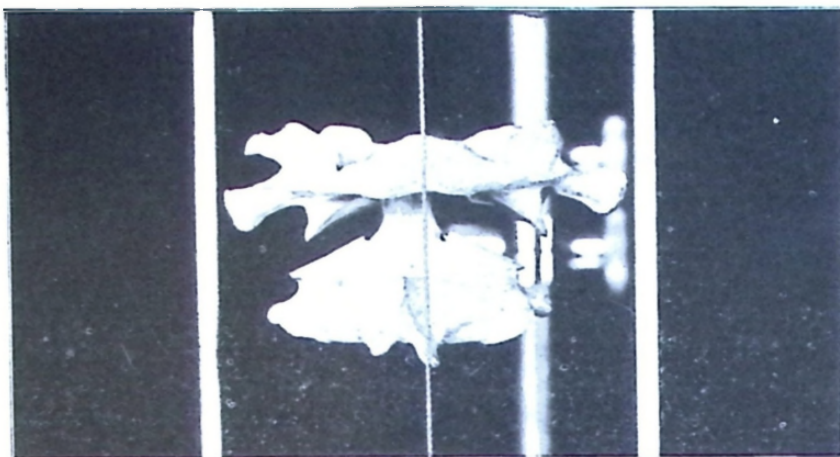


Fig. 93

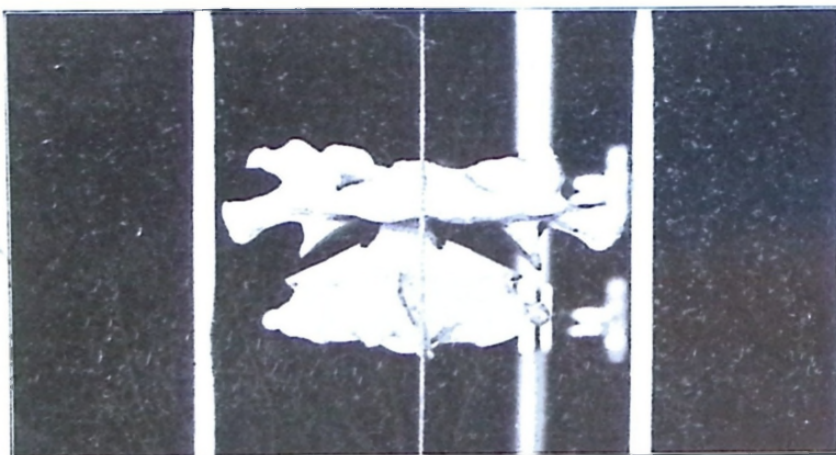


Fig. 94

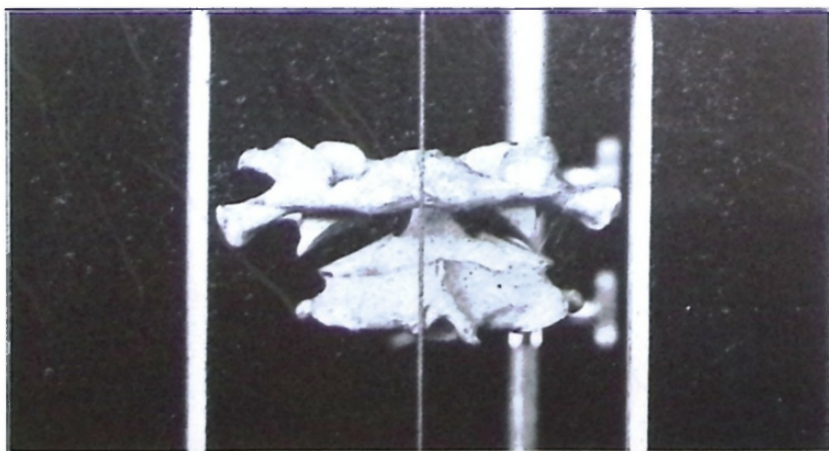


Fig. 95



Fig. 95. Left inferior sub-luxation. The spinous process of the axis is distant from the posterior arch of the atlas and combined with a left sub-luxation.

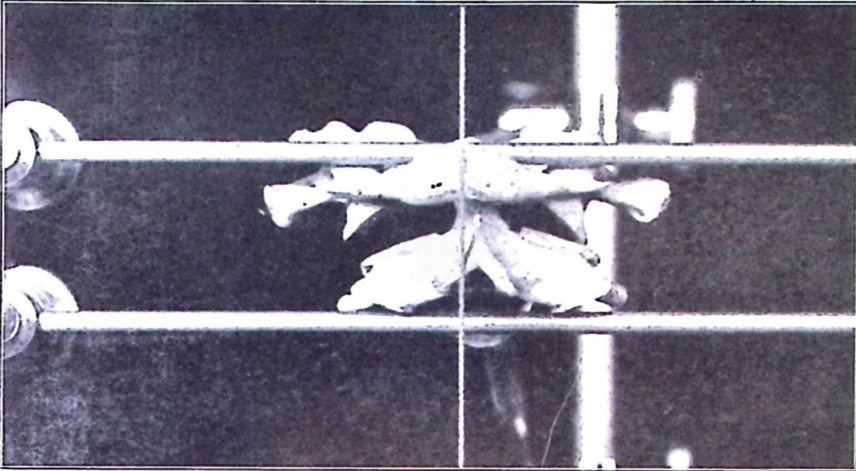


Fig. 96. Right superior sub-luxation. The spinous process is to the right of median line and closely crowding the arch of atlas upon that side.

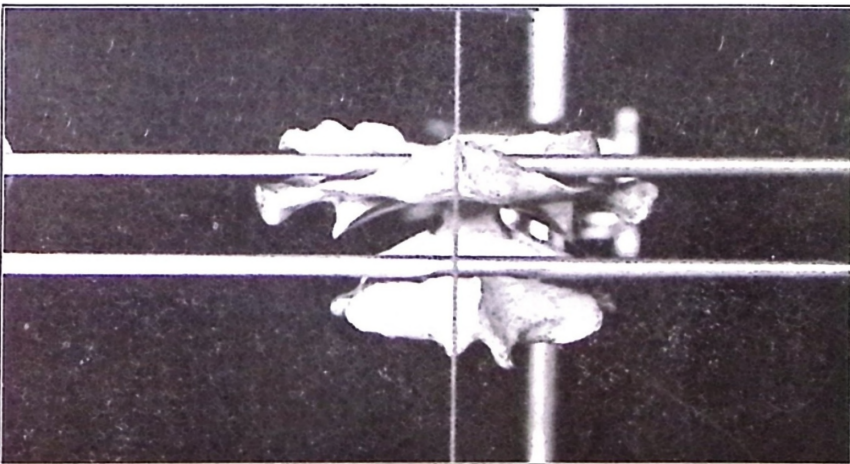


Fig. 97. Right inferior. The opposite, on the same side of Fig. 96.

##### 5. *Relative Positions of Adjacent Vertebrae.*

In the larger proportion of these enumerated sub-luxations you will positively find a previous sub-luxation of Atlas which, when compared with the present condition of

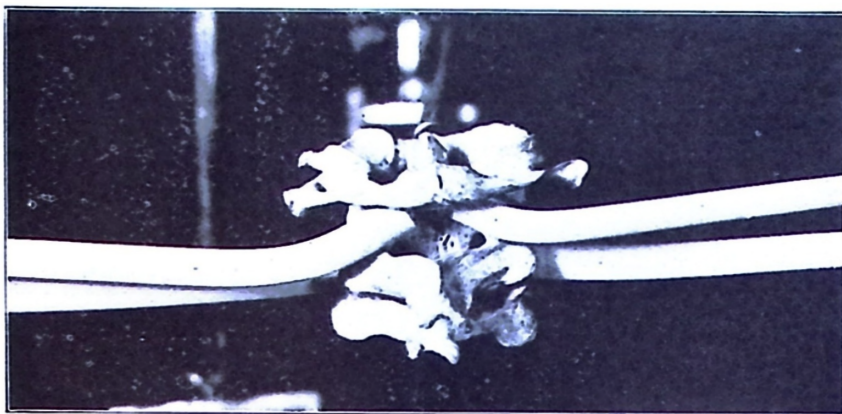


Fig. 98

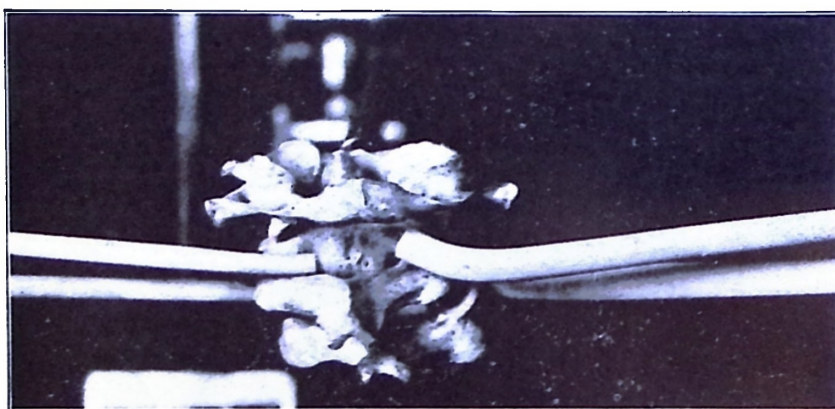


Fig. 99



Fig. 100



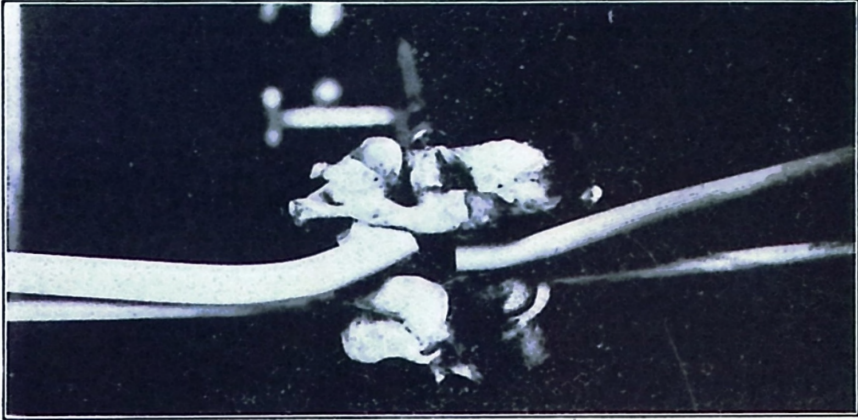


Fig. 101



Fig. 102



Fig. 103



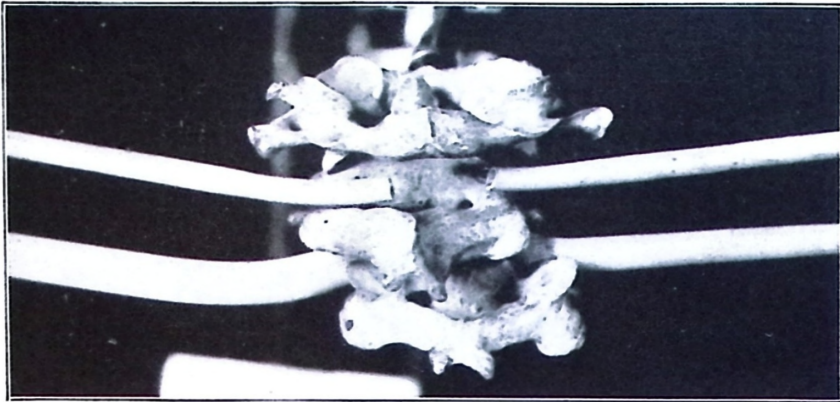


Fig. 104

Fig. 98. Four large, *normal* nerves between atlas, axis and third cervical.

Fig. 99. *Left* subluxation of axis. Pressure upon superior and inferior of axis on left.

Fig. 100. *Right* subluxation of axis. Pressures on right superior and inferior, also upon left inferior. These various combinations are found and determined by careful nerve tracings.

Fig. 101. *Left inferior* subluxation of axis. Pressures are inferior right and left.

Fig. 102. *Right superior* subluxation of axis. Pressures are superior both right and left.

Fig. 103. *Right inferior* subluxation of axis. Pressures inferior both right and left.

Fig. 104. *Left superior* subluxation of axis. Pressures superior, right and left.

this vertebra will harmonize as to how one can exist with or without the other. The correction of the Atlas, leaving the Axis alone will soon return the Axis to normal or vice versa although, if you wish, desire to, and will, adjust Axis and Atlas together it can be done, but moderation and care should be used.

#### 6. *Where Nerves Are Impinged.*

A slight change is possible in any or all foramina without any pressures, but if the general shape or size be

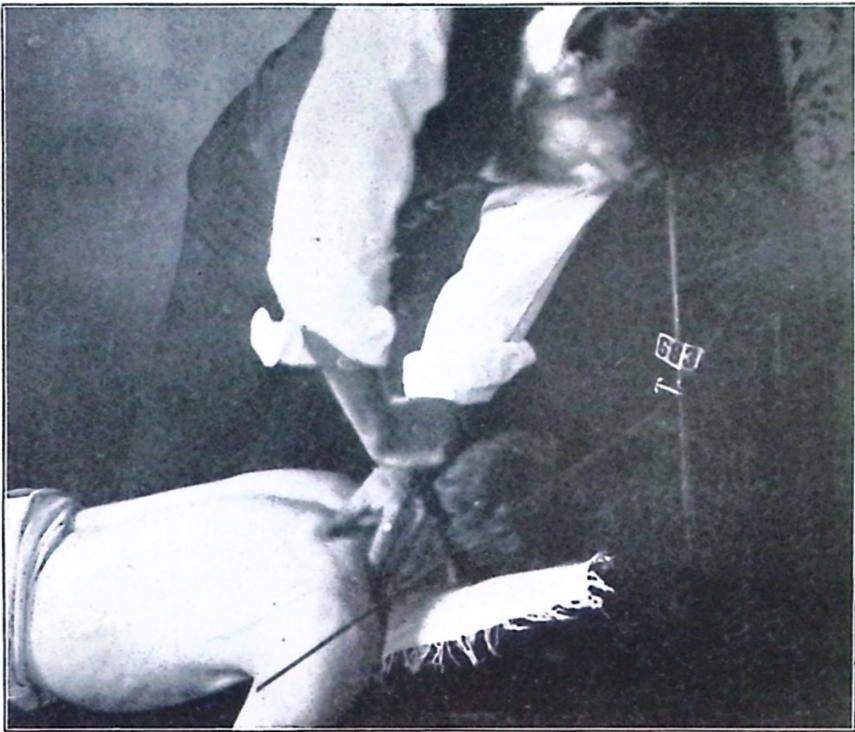


Fig. 105.



Fig. 106





Fig. 107

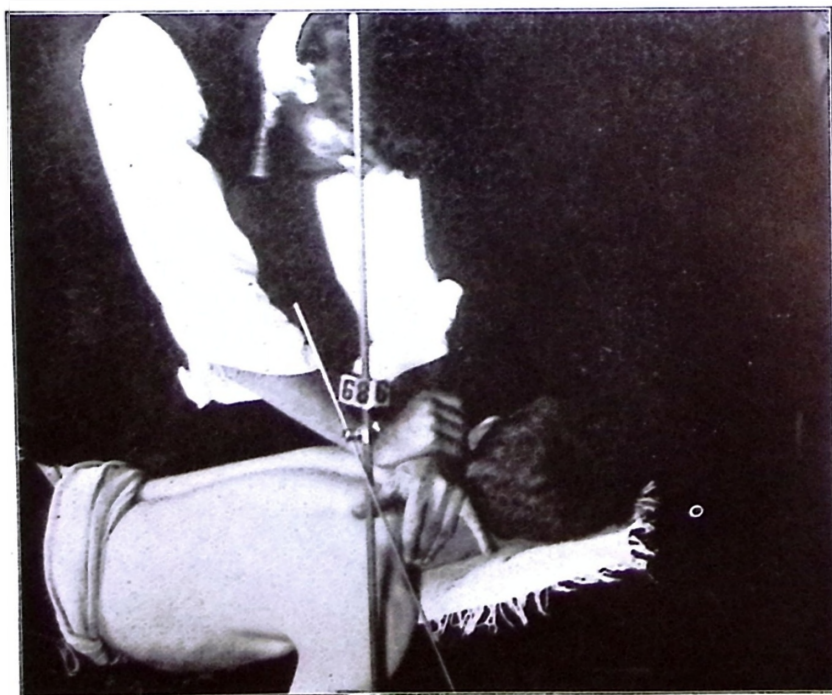


Fig. 108



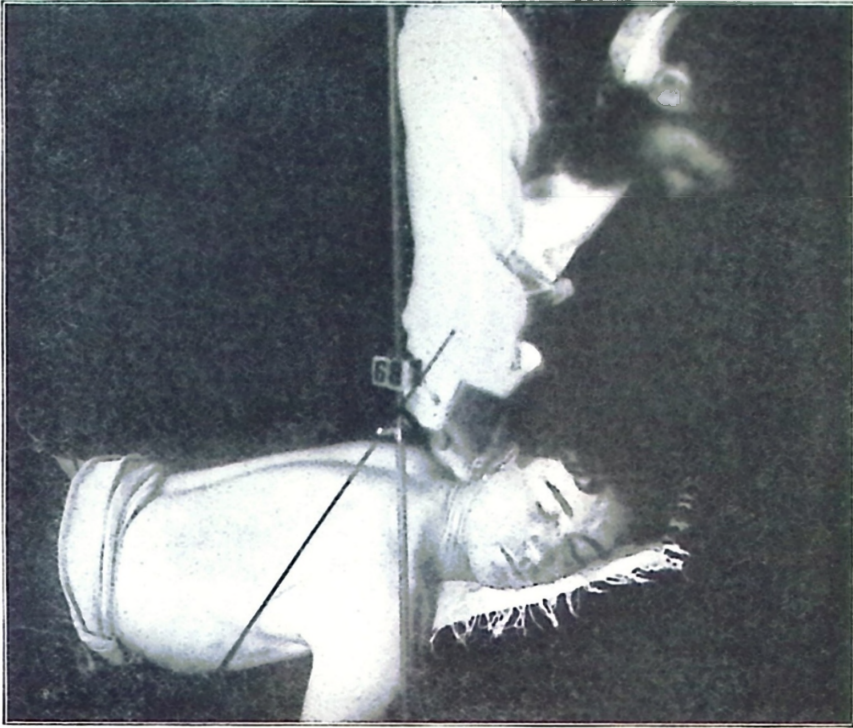


Fig. 109



Fig. 110



Fig. 111



Fig. 112





Fig. 113



Fig. 114





Fig. 115



Fig. 116

Fig. 105. *Left superior* subluxation of axis. In this adjustment the direction would be toward the right and inferior.

Fig. 106. *Left* subluxation of axis. The adjustment and force would be directed to the right.

Fig. 107. *Right lateral* subluxation of axis. The opposite to Fig. 106—to left.

Fig. 108. *Left inferior* subluxation. The opposite of this would be the correcting direction—hence—right superior adjustment.

Fig. 109. *Right superior* subluxation. Left inferior would be the direction for this movement.

Fig. 110. *If right inferior* then the direction would be as this illustration portrays—left superior.

Fig. 111. *Left superior* subluxation of axis. Using the "T. M." adjustment. The direction would be toward the right inferior as pointer indicates.

Fig. 112. *Left lateral* subluxation. Adjustment is with "T. M." Notice direction of pointer. Movement would be to right.

Fig. 113. *Right lateral* subluxation of axis. Opposite to Fig. 112. Direction would be reversed. "T. M." adjustment.

Fig. 114. *Left inferior* subluxation. Notice direction of pointer and position of head, also position of both hands. "T. M." adjustment.

Fig. 115. *Right superior* subluxation. Adjustment, with "T. M.", would be to left and inferior.

Fig. 116. *Right inferior* subluxation. Direction would be left superior. "T. M." adjustment.

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much disfigured, it is certain to produce pressures upon the soft substances (nerves) as they pass outward.

#### 8. *Functions and Organs Involved. Location of.*—

Many cases have been cited and are on record where any affections or functions of the head similar to those of

the Atlas were the diseases involved in this subluxation. In rare cases fibres spread to one or both sides involving as much as the entire external muscular control of the skull, neck and upper shoulder. The Axis covers the same field as the Atlas and only in rare instances has any keen differences been noted.

9. *Adjustments Necessary to Correct Each.*

10. *How to Give Adjustments Correctly.*

In Fig. 105 the same portions of the hand are used as are portrayed under Atlas. Inasmuch as blunders made upon this vertebra are serious propositions, I would advise ease and caution. The movement for this subluxation would be to throw the vertebra to right side and inferior, thus placing it to a median perpendicular line and by its rotation adjusting it to a normal in that direction.

Fig. 106. With the head lying upon right side of face give the adjustment quickly to that side from the left. Bear in mind the relation and subsequent changes of rotation that takes place when the thorax remains prone and the head in lying on one or the opposite side becomes turned, thus placing all cervical vertebrae in a quarter circle twist. The Atlas is perpendicular from



Fig. 117



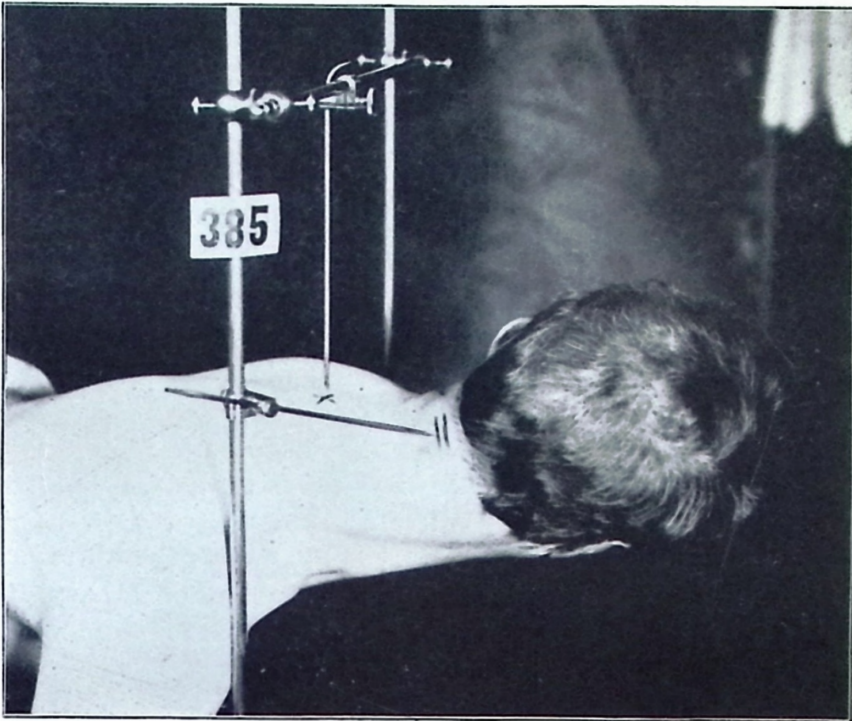


Fig. 118

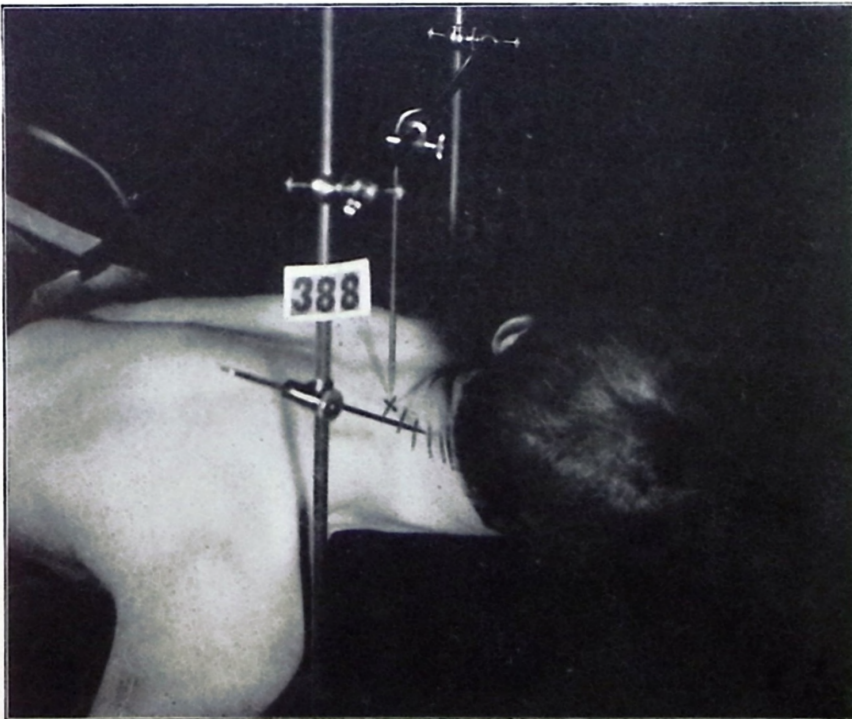


Fig. 119

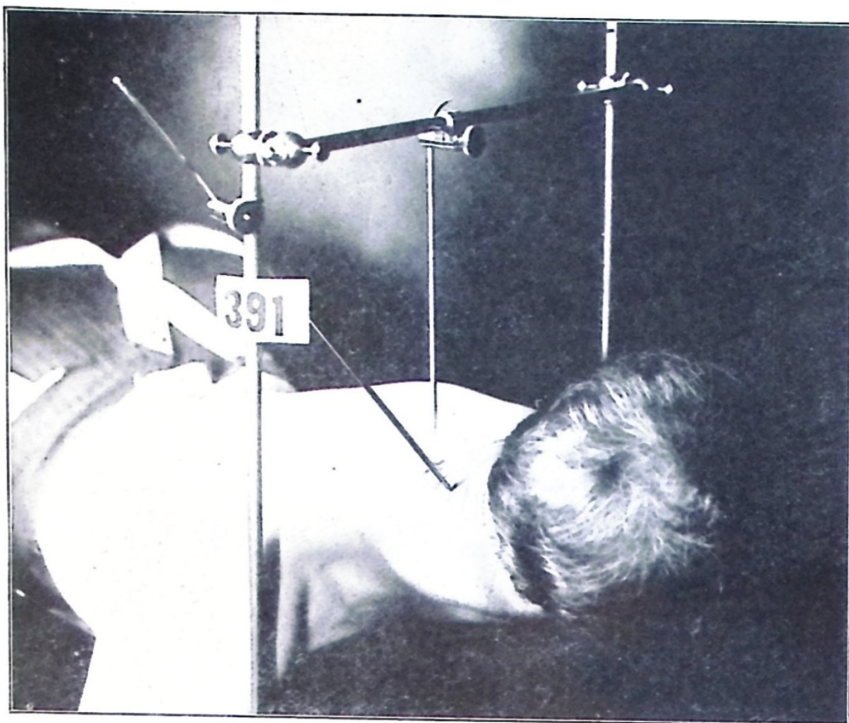


Fig. 120

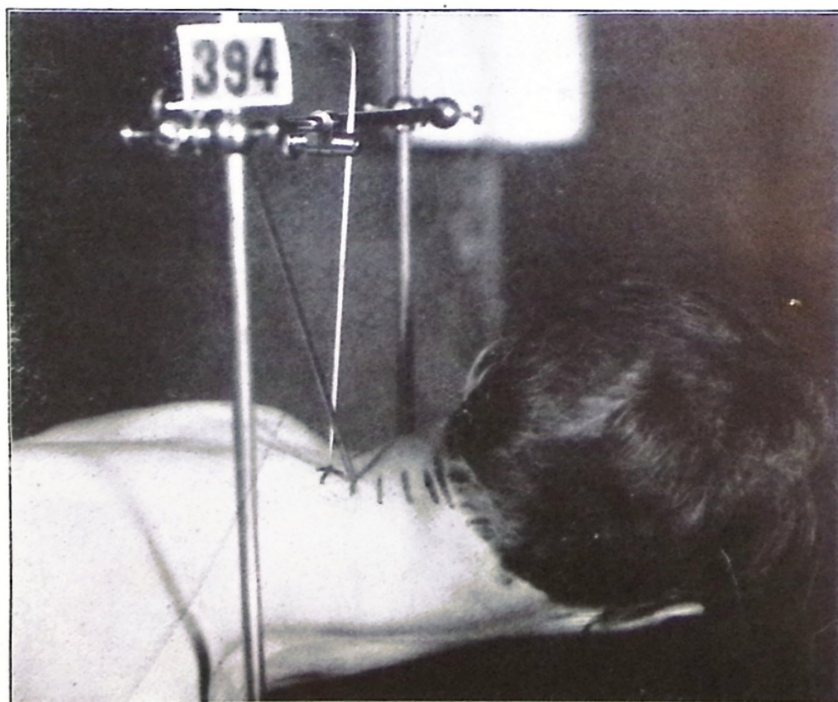


Fig. 121

Fig. 117. Showing position, on quarter circle turn, when ready for adjustment. The pointer, indicating spinous process of axis is horizontal and superior pointer showing spinous process of 7th cervical is plumb. *One quarter circle.*

Fig. 118. Patient lying, showing position of *third* cervical in the quarter circle curve.

Fig. 119. Patient prone showing position of *fourth* cervical in the curve.

Fig. 120. Patient lying down showing position of *fifth* cervical around the curve.

Fig. 121. Patient lying, showing position of *sixth* cervical in the curve.

above downward while in this position, beginning at this point, is made a complete quarter circle by the reversion of the cervical. The greatest point of obliquity is at the 4th which is not square to either direction an  $\frac{1}{2}$  of a 45 degree slant but if a line were drawn through its spinous process and centrum running for a distance to its rear, it would extend directly upward and outward midway between a horizontal and perpendicular line. The posterior tubercle of the Atlas and spinous process of the seventh cervical would be at right angles.

Fig. 107 would be direct opposite of Fig. 106. If adjusting the Axis to the right side, use right hand for palpation and acting as a director and guide, and the left, the nail hand, for giving the adjustment. If the vertebra is to be thrown to the left side use left hand for palpation and the right for the nail hand. Always remember to figure the degree of slant you have in your case on the bench and adjust accordingly.

As in driving a nail, it is well to determine that all adjustments are, unless symptoms justify otherwise, given perpendicular to the surface and degree of slant. In movements of Axis do not drive so obliquely that you force the head from the table.



Fig. 108. The adjustment is superior and to right.

11. *What means and portions thereof to use.*

The hands are the *only* tools and the means and portions thereof, as spoken of in adjustments of the Atlas, hold good with the Axis.

12. *What Diseases to Adjust the Axis for.*

In cases where the region surrounding the Atlas transverse croth is swollen with boils, tumors, serodema or cancers, so that adjustments directly upon the transverse processes of Atlas are impossible, we are justified in accomplishing through Axis what ought to be done to Atlas alone. The diseases following subluxations of Axis are in general, covered by those of the Atlas, while adjusting this vertebra may accomplish as good or better results. This is where you rely upon your judgment following what is determined after a very careful palpation. Research has not located a trouble at this subluxation other than what has been mentioned under the similar head of Atlas.

The reason being that subluxations occur more frequently and in greater degrees where the greatest mobility exists which in cervical is the atlas and axis and the cervical's center—4th.

CHAPTER 6.  
THIRD CERVICAL.



Fig. 122.

1. *Vertebra and its Title. U. C. P.*

Although this spinous process is deeply imbedded into the concavity of the posterior of the neck and is approximate to the Axis it is frequently the recipient of blows that fracture the tender projections. Although we are told these are rare, the Chiropractor finds them quite common. The sudden jerking or forcing the head backward upon the shoulders by a blow on top of the head or forehead will, in a large majority of cases, tense the skull posteriorly until a fracture occurs.

Here is one basis for the external force which, while it produces the fracture, also creates a subluxation with its chronic symptoms following.

2. *Superficial Palpation and Land Marks.*

The spinous process of this vertebra, when the person

stands erect with the head upright, is, on the average, difficult to fell. The spinous process of the Axis being prominent and the third short, the latter usually lying up against it very closely, its bifurcations overlapping, makes it a difficult vertebra to palpate. The best position for ascertaining its normal attitude is to drop head forward upon the chest, thus spreading the processes apart and in bowing the neck forward creates a posterior curve making position more accurately determined.

Of the cervical, the third has the shortest process, and as a rule its two bifurcations are less lengthy and lie proportionately closer to its superior mate than any other. It has no prominent transverse process. In this respect is less often palpated than the Axis, although farther from the occiput.

The following details, point by point, show how to know a subluxation from a normal position.

Pt. A. Determine which hand to be used according to side you are on. Left hand for palpating when on right side. Right hand for palpating when on left side. Left hand is the nail hand on left side, and right hand is for the same purpose when standing on the right side.

Pt. B. Do *all* palpating where normal or abnormal positioned vertebrae are concerned, with the 1st, 2nd and 3d fingers evenly placed.

Pt. C. Determine where the vertebral processes are *posterior* of the median line. This is done by comparison with three fingers and three vertebrae, and with a gliding movement on top of the spinous processes.

Pt. D. Find whether right or left by comparison on left or right side of the vertebral processes. This is done by a running movement of the fingers along each side.

Pt. E. *The* spinous process must be exactly located and then spaces discriminated between to ascertain whether it crowds the inferior one; if so it is an inferior subluxation in addition to the other positions. If too close to the one above, it is superior. This is determined by placing the center finger on the posterior process and dropping the finger above into the space between that and



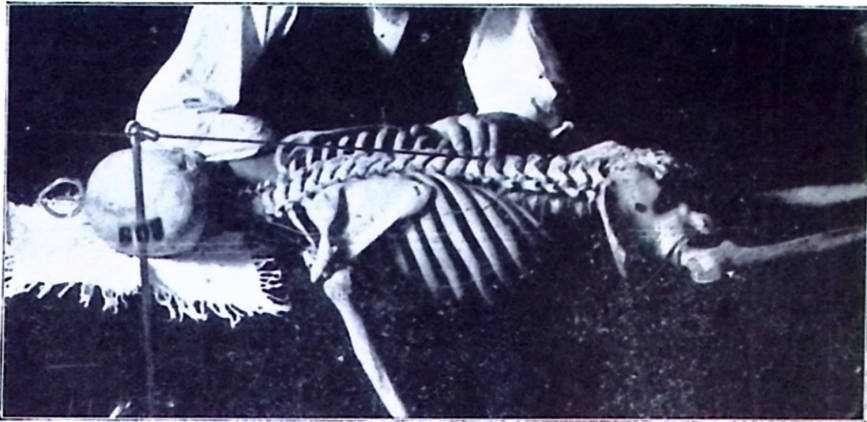


Fig. 123. When palpating use *left* hand on right side.

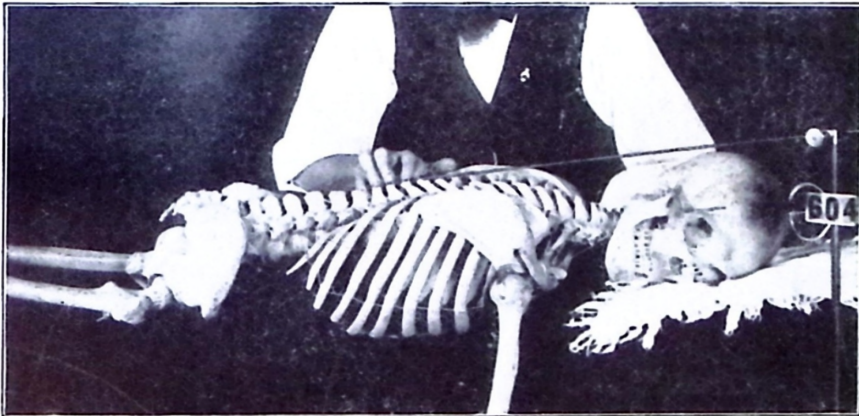


Fig. 124. When palpating use *right* hand on left side.



Fig. 125. *Left* hand is the nail hand on left side.

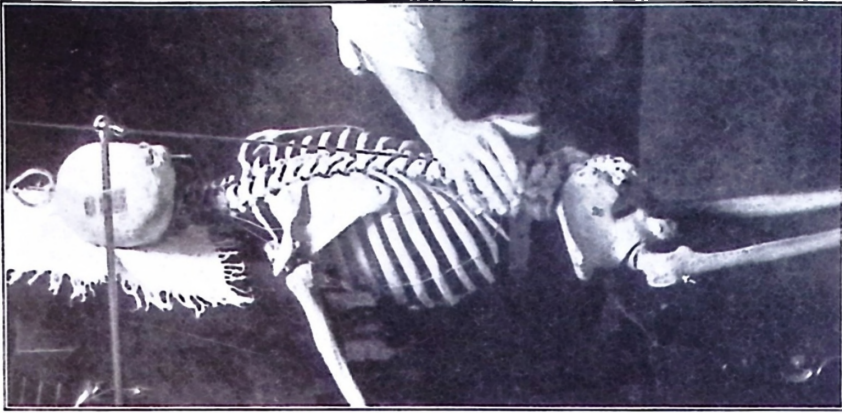


Fig. 126. *Right hand is the nail hand on right side.*

its contiguous process, and the other below it and then compare the relative spaces. This is determined, not by a running movement, but by a stationary comparison.

Pt. F. Aafter ascertaining these important points, let the middle finger of the hammer hand remain, drawing toward you so that you are off, yet adjoining the process, taking away the 1st and 3rd fingers, placing them under the fist. By then laying that hand close to the back it leaves you an index pointer to the sublaxation.

Pt. G. The nail point of the hand that adjusts is now placed on the spinous process that has been proven to be sublaxated.

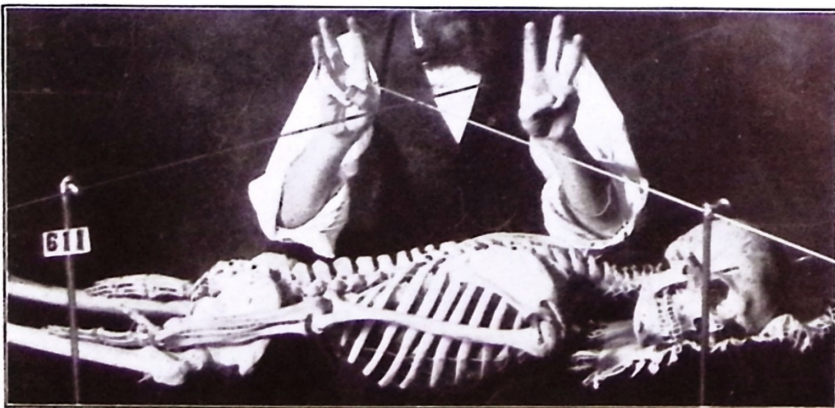


Fig. 127. Remember to do all palpating with three finders; 1st, 2nd, and 3rd.



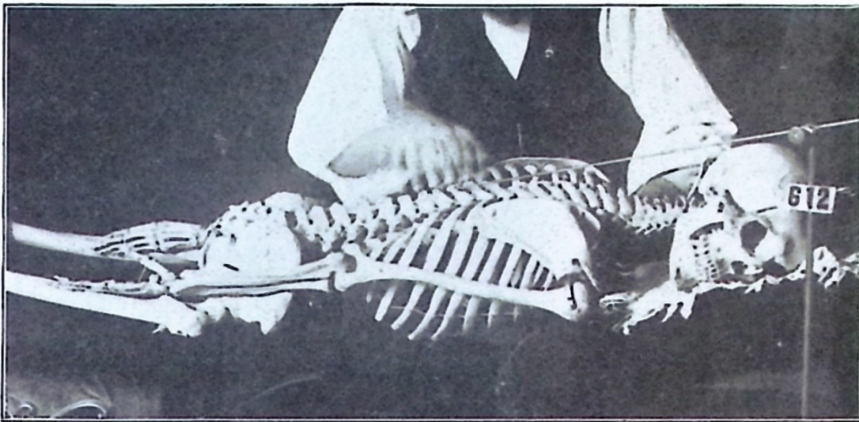


Fig. 128. Notice gliding movement of three fingers portrayed.

Pt. H. The hammer head of the opposite hand is now placed on the nail process of the hand that remains stationary on the neuropophysis.

Pt. I. When hands are placed properly, determine the direction that adjustments must be made, which is opposite to the character of the subluxation.



Fig. 129. Determining whether subluxation is left or right.

Pt. J. Determine whether to use nail points 1-2 or 3 according to Fig. 148. 1 is used exclusively for "T. M." adjustments. 2 on all dorsal, lumbar or sacral adjustments, 3 exclusively for cervical adjustments.



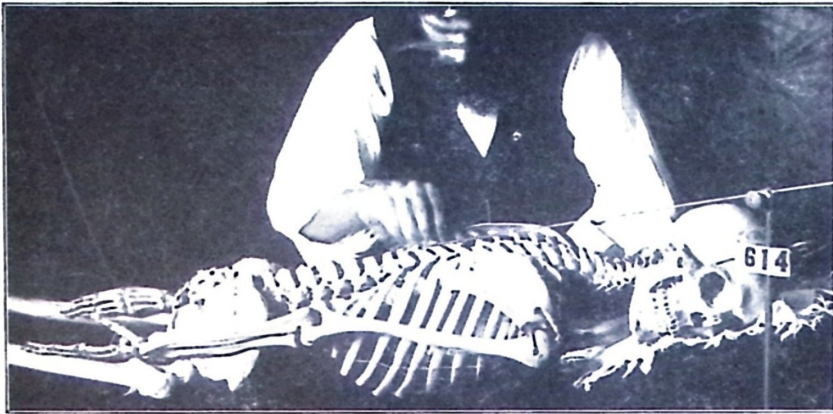


Fig. 130. Determining whether the subluxation is superior or inferior.

Pt. K. Place your body in that direction to economize forces, and get the most from the least exertion on your part.

Pt. L. Give the adjustment.

### 3. *Normal Position and Articulations.*

Each succeeding vertebra of the cervical has six articular surfaces and when joined with the approximate ver-



Fig. 131. See Pt. F.

tebra above and below complete articulations. Two superior and two inferior articulations through the zygapophyses. If this vertebra be in normal position it will be in opposition with all its articulations.

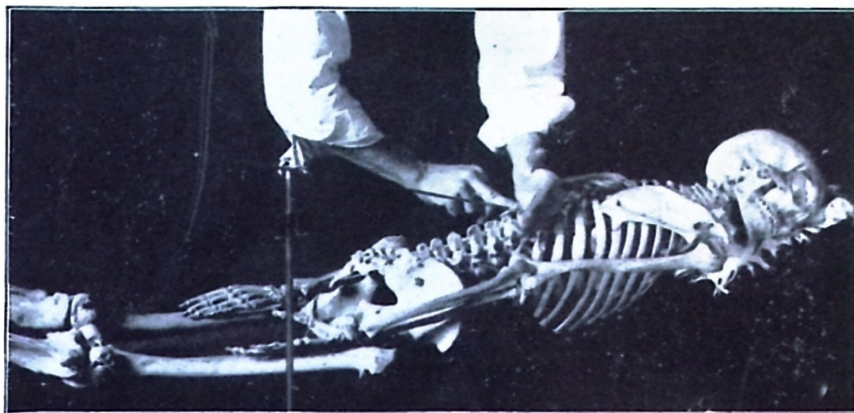


Fig. 132. See Pt. G.

4. *Sub-luxations, described and illustrated.*

The movements that the Atlas and Axis are based around are peculiar. So much do they vary from the general rule that I prefer to speak of them as in a class by themselves. The 3rd cervical will thus vary from the above in one respect which will be common to all vertebrae, the



Fig. 133. Exemplifies Pt. H., with pointer showing the hammer head of hammer hand placed over the nail head.

superior or inferior subluxation which, when referred to in preceding chapters was in combination with some other. In the following it may be distinct and alone.

Of this vertebra and following vertebrae we have no anterior subluxations but distinctly and briefly only 4 pos-



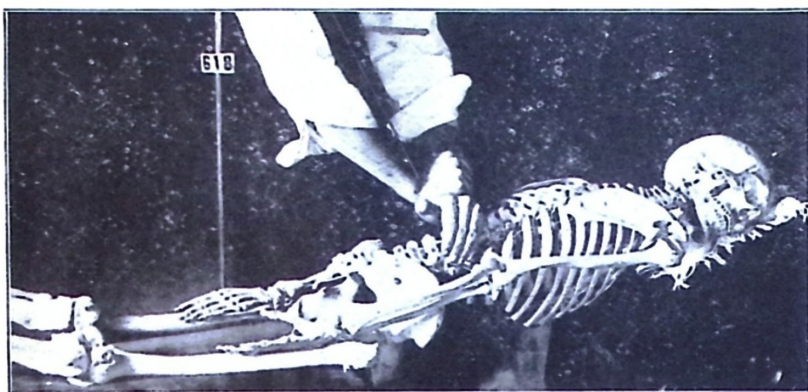


Fig. 134



Fig. 135

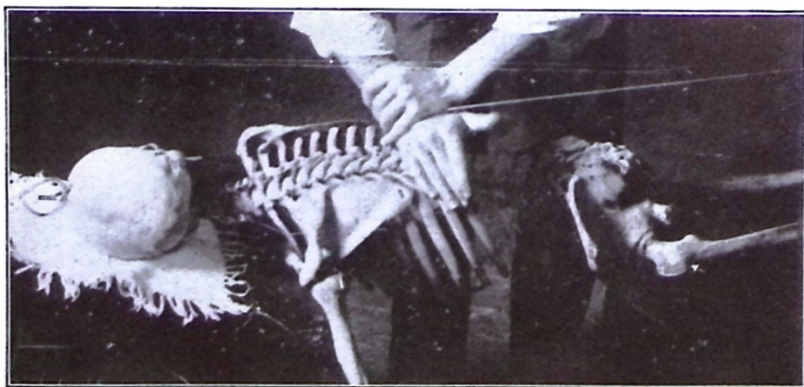


Fig. 136



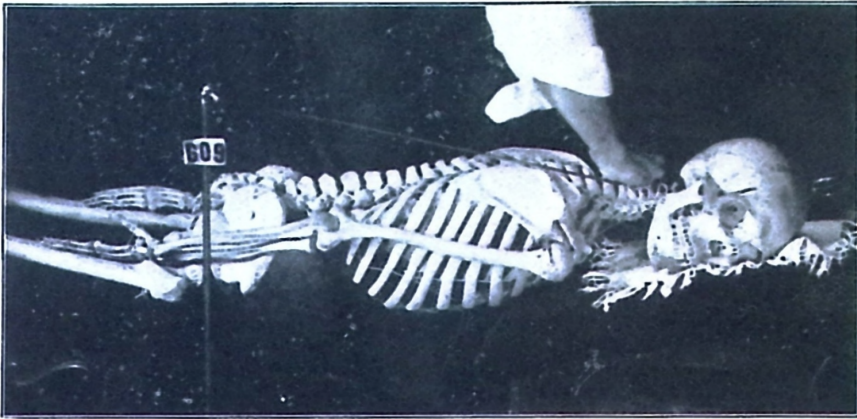


Fig. 137

sible posterior abnormal positions, a posterior, lateral, superior or inferior.

- Fig. 168. Left subluxation of 3rd cervical.
- Fig. 169. Right subluxation of 3rd cervical.
- Fig. 170. Superior subluxation of 3rd cervical.
- Fig. 171. Inferior subluxation of 3rd cervical.
- Fig. 172. Left, superior subluxation.
- Fig. 173. Right inferior subluxation of 3rd cervical.
- Fig. 174. Left inferior subluxation of 3rd cervical.
- Fig. 175. Right superior subluxation of 3rd cervical.
- Fig. 176. Posterior subluxation of 3rd cervical.
- Fig. 177. Posterior superior subluxation of 3rd cervical.
- Fig. 178. Posterior inferior subluxation of 3rd cervical.



Fig. 138

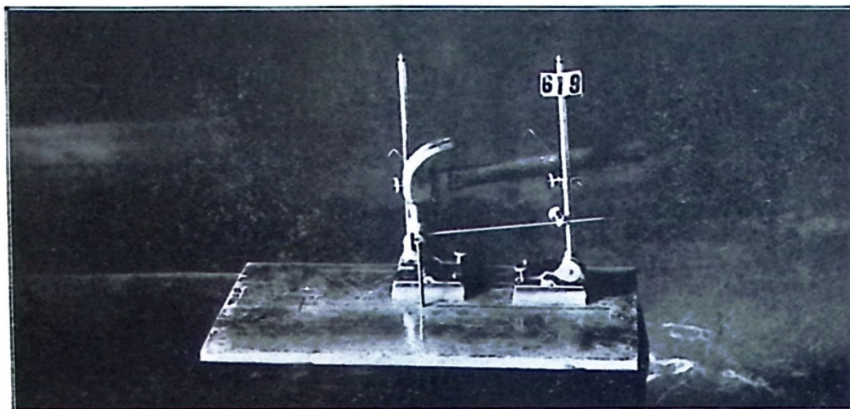


Fig. 139.

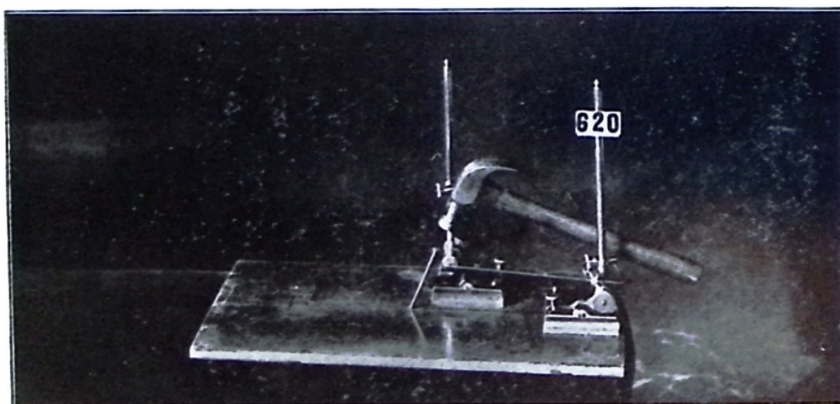


Fig. 140

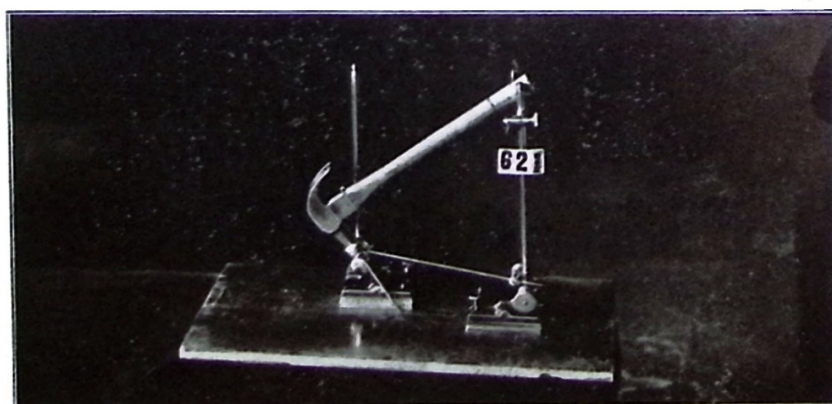


Fig. 141



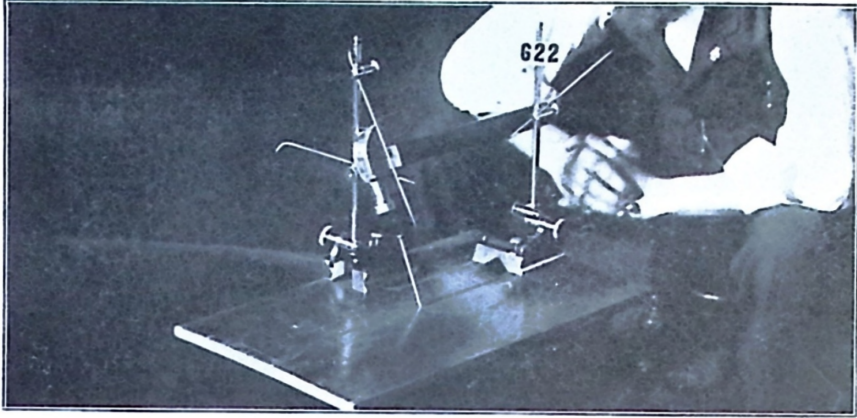


Fig. 142

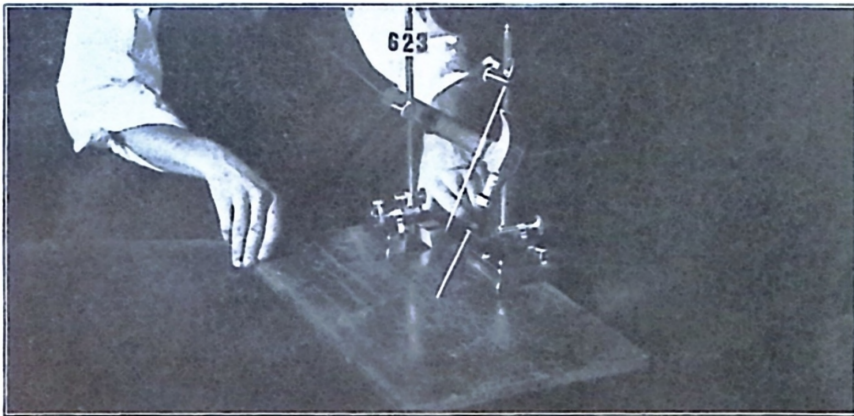


Fig. 143



Fig. 144



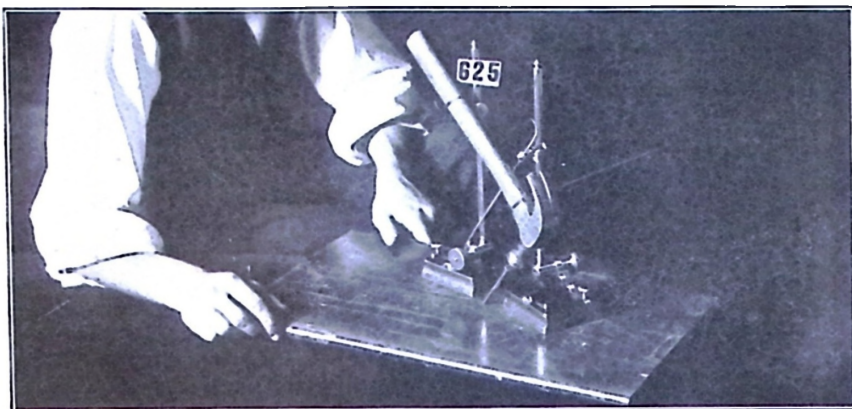


Fig. 145

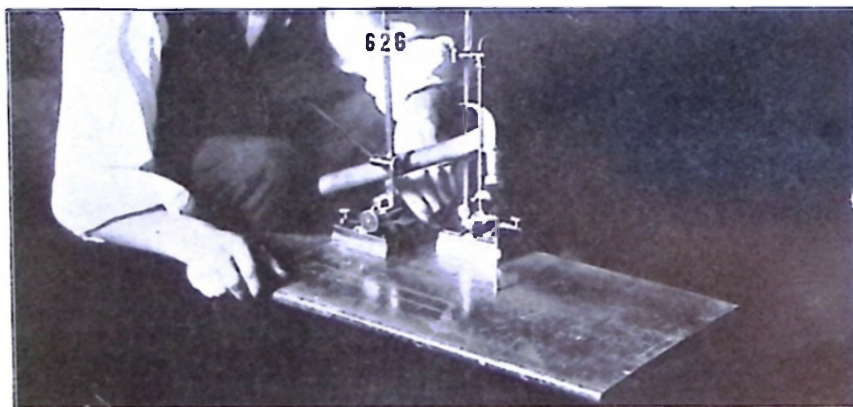


Fig. 146



Fig. 147

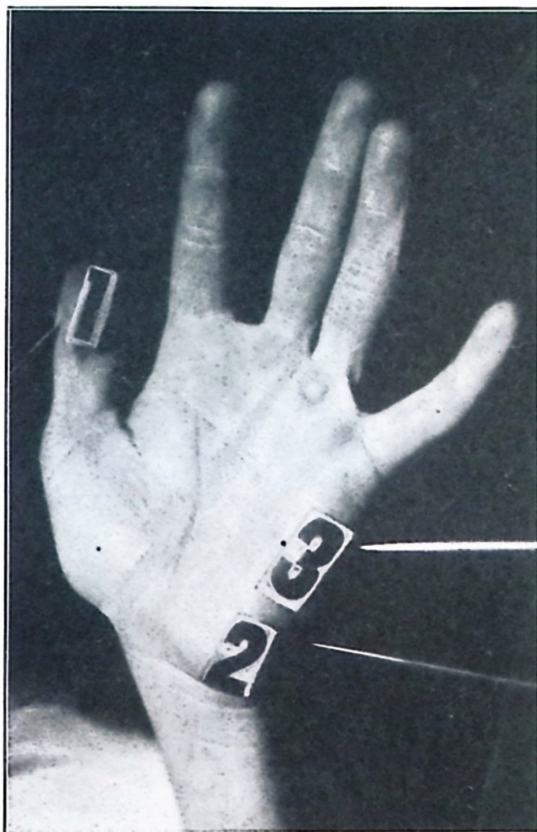


Fig. 148

In this series of combinations an almost endless chain of possibilities can and does occur. Especially are these conditions met with and proven to exist in torticollis and wryneck, where osteomalacia or mollities ossium has greatly compressed one or both sides to conform to this plan and manner of procedure.

5. *Relative positions of adjacent vertebrae.*

The relative positions of vertebrae above and below can easily be determined by close study of the foregoing illustrations. The superior vertebrae remain as a fixed point while the lower one assumes the subluxated positions.

(Con. page 117)

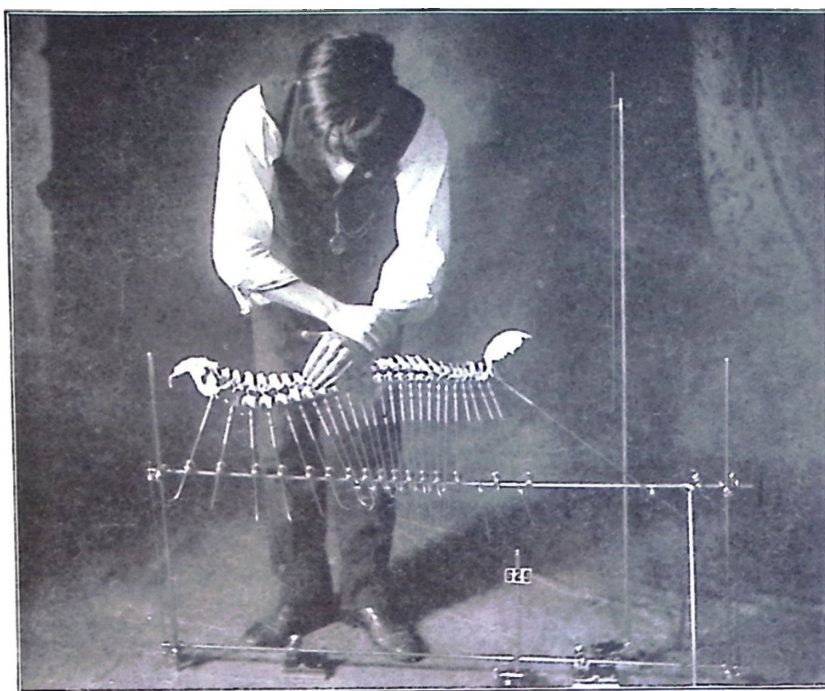


Fig. 149

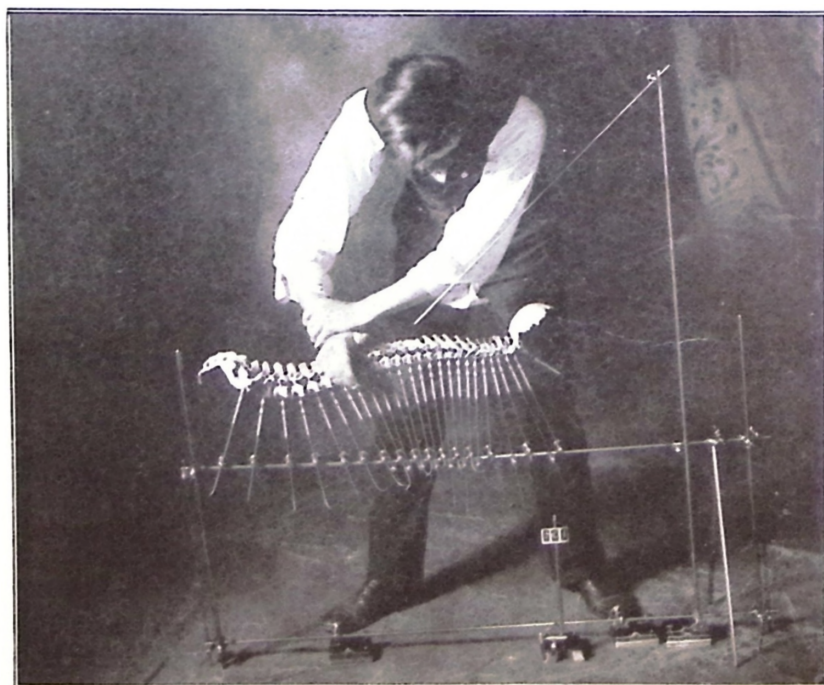


Fig. 150



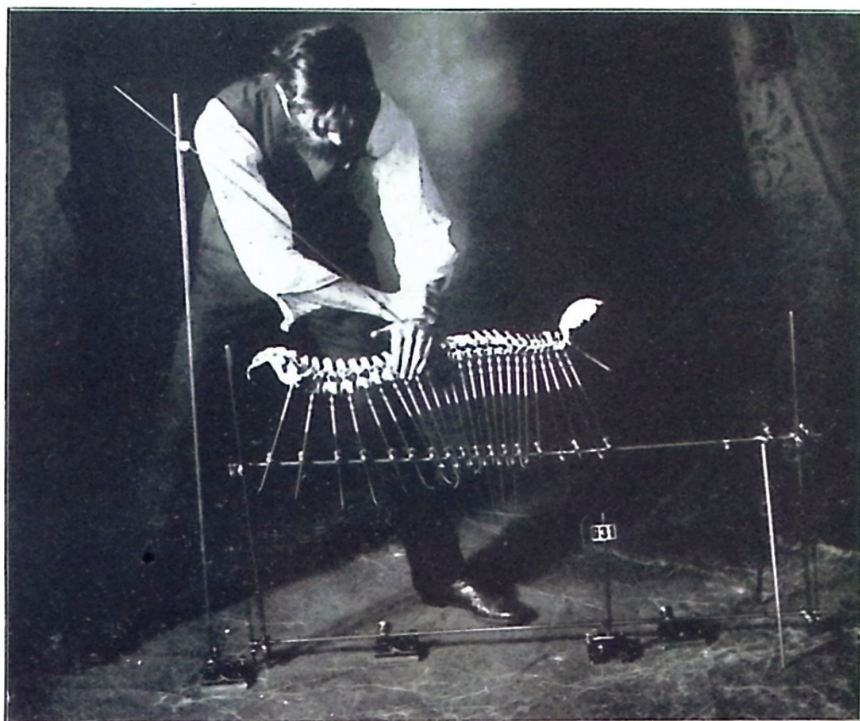


Fig. 151



Fig. 152



Fig. 153



Fig. 154





Fig. 155

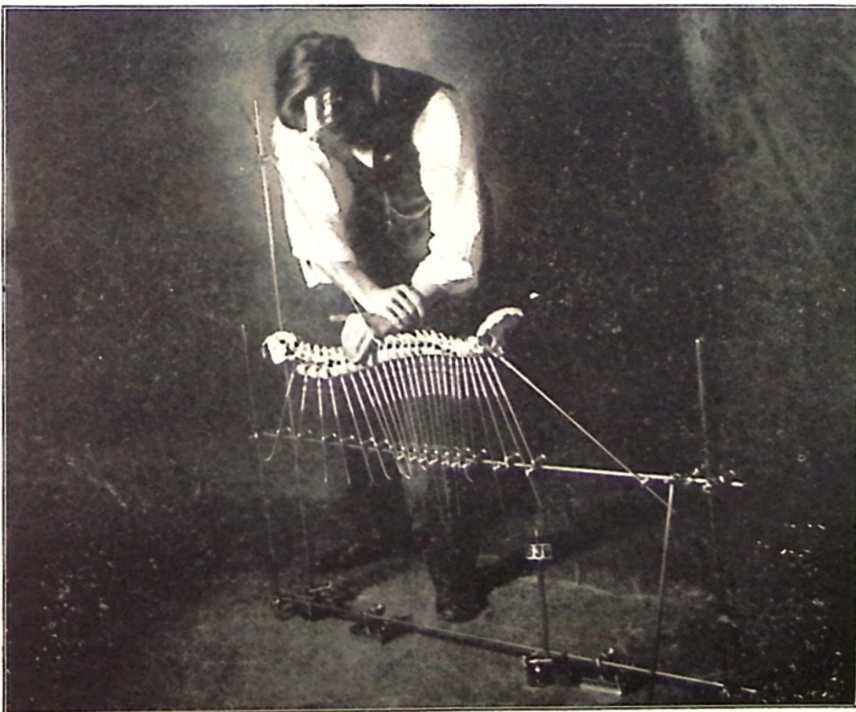


Fig. 156



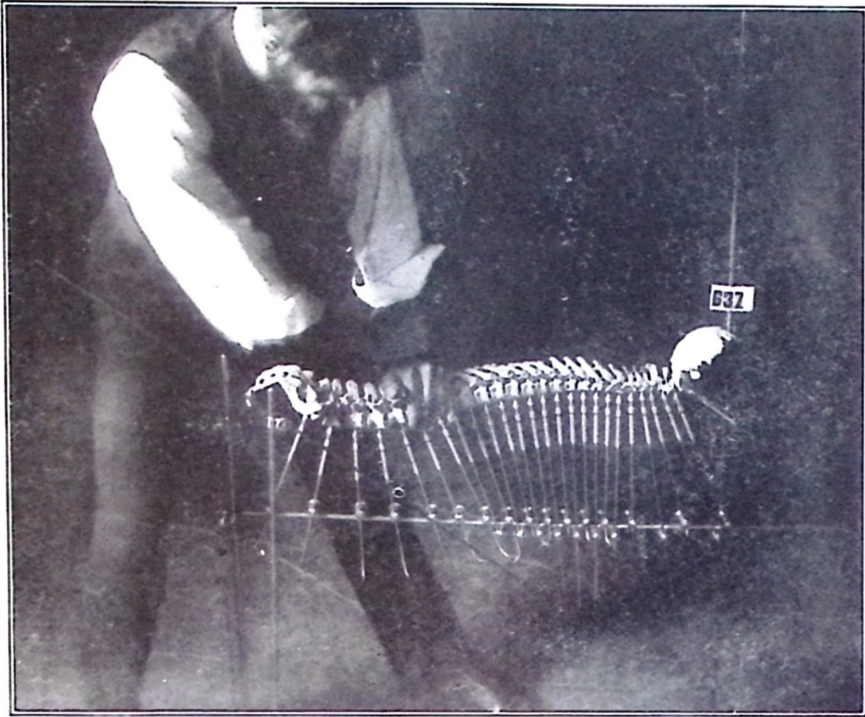


Fig. 157

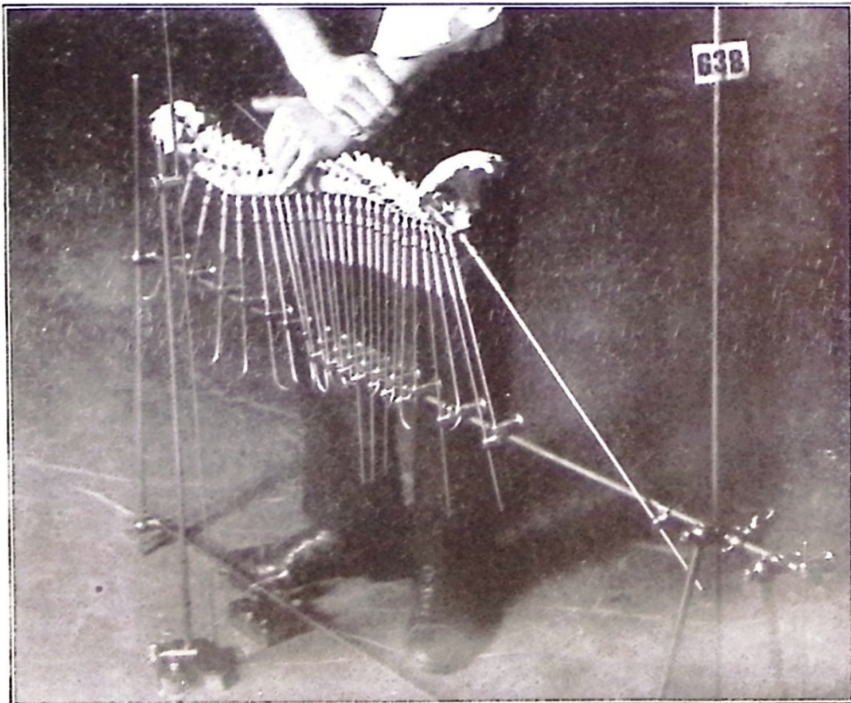


Fig. 158

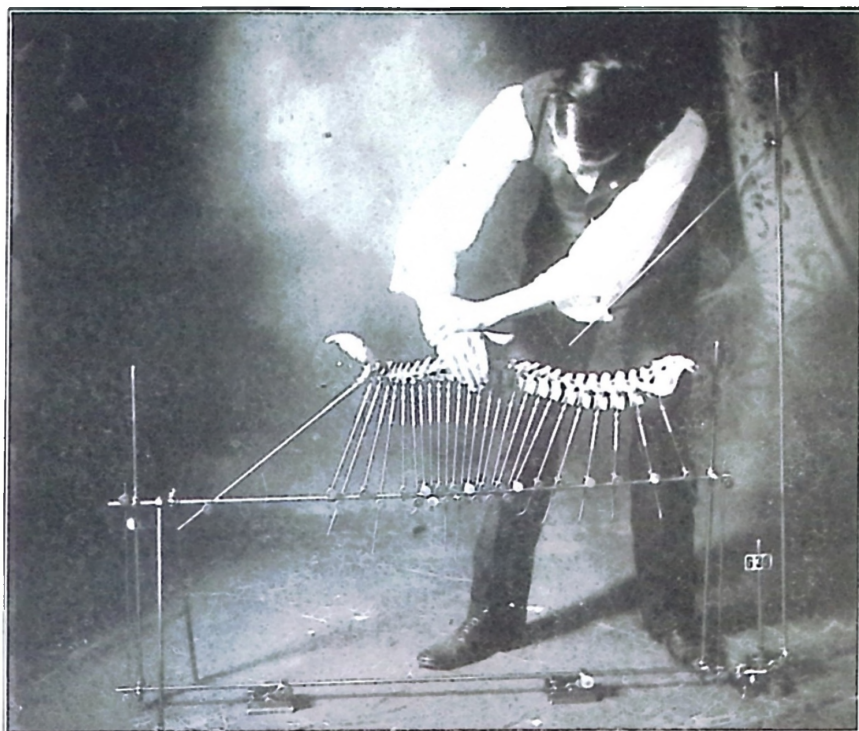


Fig. 159



Fig. 160





Fig. 161



Fig. 162



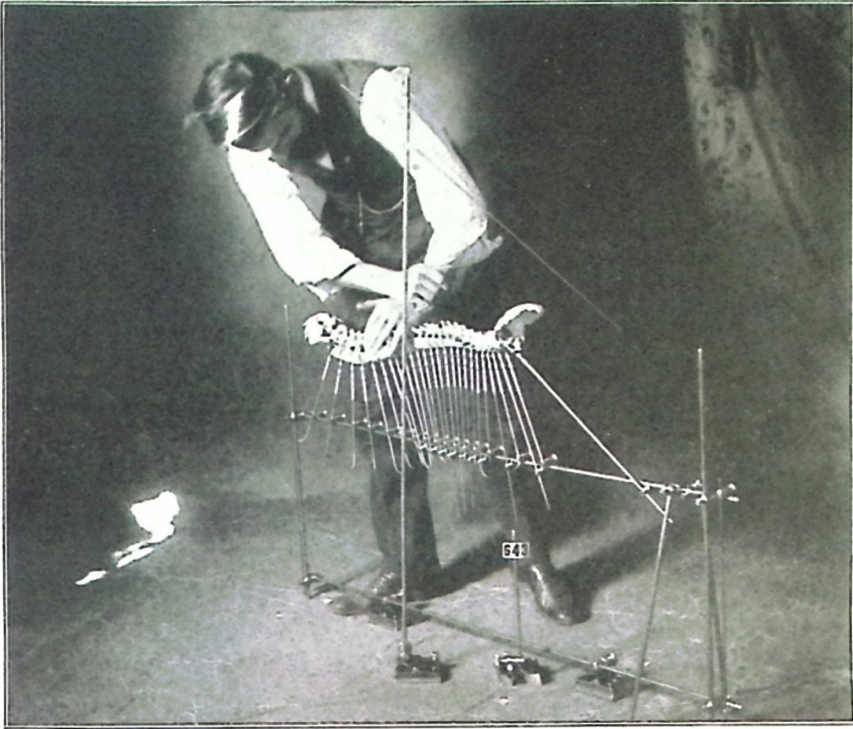


Fig. 163.



Fig. 164



Fig. 165



Fig. 166

Fig. 134. Exemplifying Pt. H. further, by pointer indicating hammer head. Notice proper position of hands.

Fig. 135. Demonstrates Pt. H. with *right* hand as the nail hand and left hand as the hammer hand when on right side of patient.

Fig. 136. Same as Fig. 135 with the *left* hand as the nail hand and *right* hand as the hammer hand when on left side of patient.

Fig. 137. The only place that this rule varies is in the cervical *when the face is from you*. Then the *right* hand is the nail hand on the left side.

Fig. 138. The *left* hand is the nail hand on the right side in cervical adjustments.

Fig. 139. Showing hammer and nail adjusting *anterior*.

Fig. 140. Showing hammer and nail adjusting *superior and anterior*.

Fig. 141. Showing hammer and nail adjusting *inferior and anterior*.

Fig. 142. Showing hammer and nail adjusting to the *left and anterior*.

Fig. 143. Showing hammer and nail adjusting to the *right and anterior*.

Fig. 144. Showing hammer and nail adjusting *left superior and anterior*.

Fig. 145. Showing hammer and nail adjusting *left inferior and anterior*.

Fig. 146. Showing hammer and nail adjusting *right superior and anterior*.

Fig. 147. Showing hammer and nail adjusting *right inferior and anterior*.

Fig. 149. Body in position and hands properly placed ready to adjust *anterior*.

Fig. 150. Body in position and hands properly placed ready to adjust *inferior*.

Fig. 151. Body in position and hands properly placed ready to adjust *superior*.

Fig. 152. Body in position and hands properly placed ready to adjust *right*.



Fig. 153. Body in position and hands properly placed ready to adjust *left*.

Fig. 154. Body in position and hands properly placed ready to adjust *left superior*.

Fig. 155. Body in position and hands properly placed ready to adjust *left inferior*.

Fig. 156. Body in position and hands properly placed ready to adjust *right superior*.

Fig. 157. Body in position and hands properly placed ready to adjust *right inferior*.

Fig. 158. Body in position and hands properly placed ready to adjust *anterior*, drawing the vertebra to the side upon which you stand.

Fig. 159. Body in position and hands properly placed ready to adjust *superior*, drawing the vertebra to the side upon which you stand.

Fig. 160. Body in position and hands properly placed ready to adjust *inferior*, drawing the vertebra to the side upon which you stand.

Fig. 161. Body in position and hands properly placed ready to adjust *left*, drawing the vertebra to the side upon which you stand.

Fig. 162. Body in position and hands properly placed ready to adjust *right*, drawing the vertebra to the side upon which you stand.

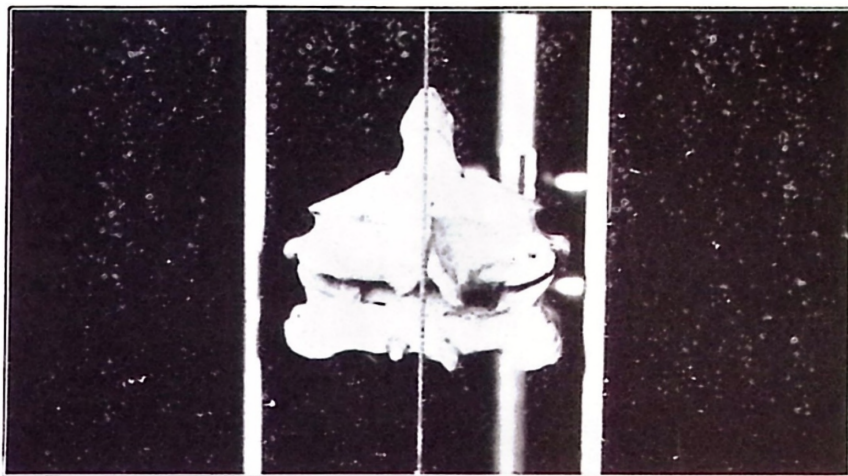
Fig. 163. Body in position and hands properly placed ready to adjust *left superior*, drawing the vertebra to the side upon which you stand.

Fig. 164. Body in position and hands properly placed ready to adjust *left inferior*, drawing the vertebra to the side upon which you stand.

Fig. 165. Body in position and hands properly placed ready to adjust *right superior*, drawing the vertebra to the side upon which you stand.

Fig. 166. Body in position and hands properly placed ready to adjust *right inferior*, drawing the vertebra to the side upon which you stand.

---



6. *Where Nerves are Impinged.*

Fig. 166. There would be no pressures, as all foramina are normal in size and shape.

Fig. 168. In this condition the pressures would be upon one or both of the nerves issuing from the left side.

Fig. 169. This would be the reverse of Fig. 168. We must bear in mind that while this is the usual condition, it is susceptible to being often questioned because cases vary in this respect in formation of their bones, etc., that

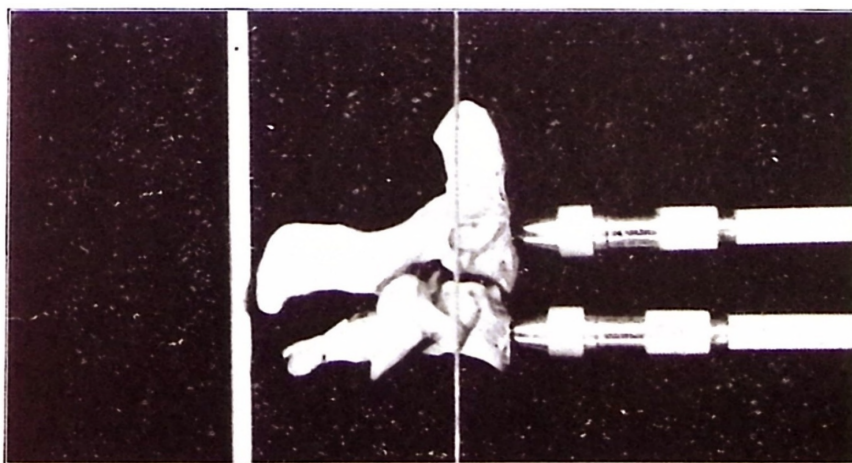


Fig. 167. *Right lateral view of axis and third cervical showing depression of spinous processes with plumb bar.*

This proves the size to be all that a Chiropractor could wish.

makes any rule inapplicable to all cases, but 12 years at this work has proven where the greatest average of pressures exist with certain subluxations.

Fig. 170. The pressure would be upon the nerves issuing from both sides of the superior surface. The raising of the posterior or of the inferior vertebra is what crowds the space and brings the two halves of the intervertebral foramina together into a smaller opening.

Fig. 171. The opposite of Fig. 170 would exist here.

Fig. 172. In this specimen we have a combination of Fig. 168 and 170 which would create pressure upon that side and superior portion. We might find pressures upon both sides but the left will be greater.

Fig. 173. Here we have a combination of Figs. 169 and 171 on inferior of right side.

Fig. 174. The pressure in this subluxation would be on left inferior of 3rd cervical.

Fig. 175. Pressure would exist in foramina on right superior of 3rd cervical.

Fig. 176. In a "posterior subluxation" pressure may be upon any one, two, three or four of the foramina that surround the subluxated vertebra. A posterior is hardly

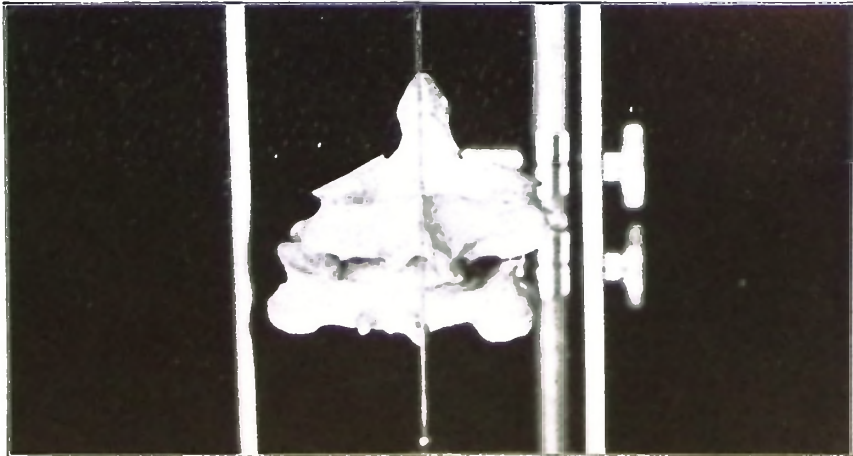


Fig. 168.



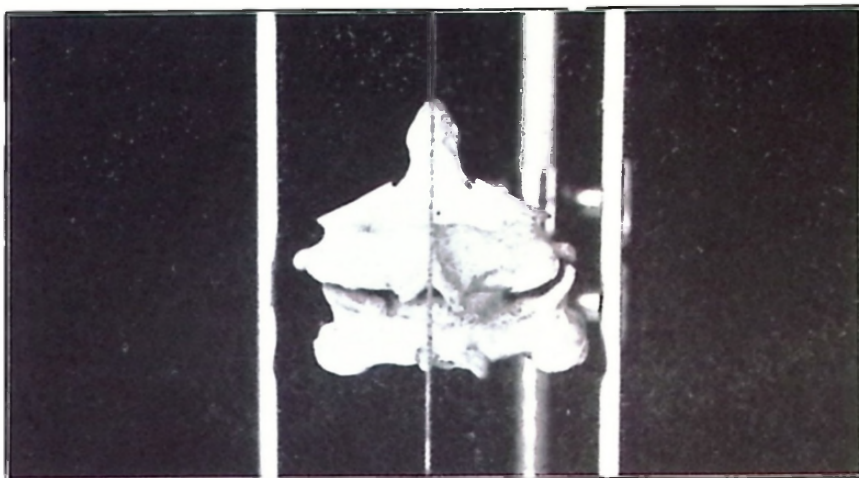


Fig. 169.

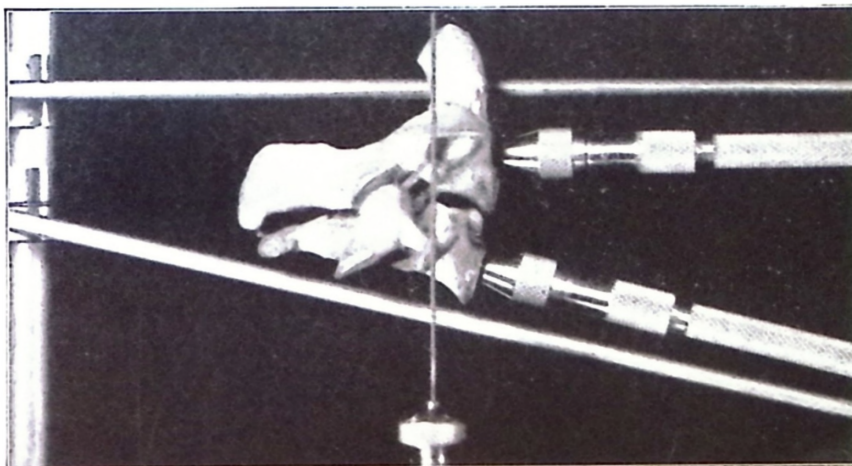


Fig. 170.

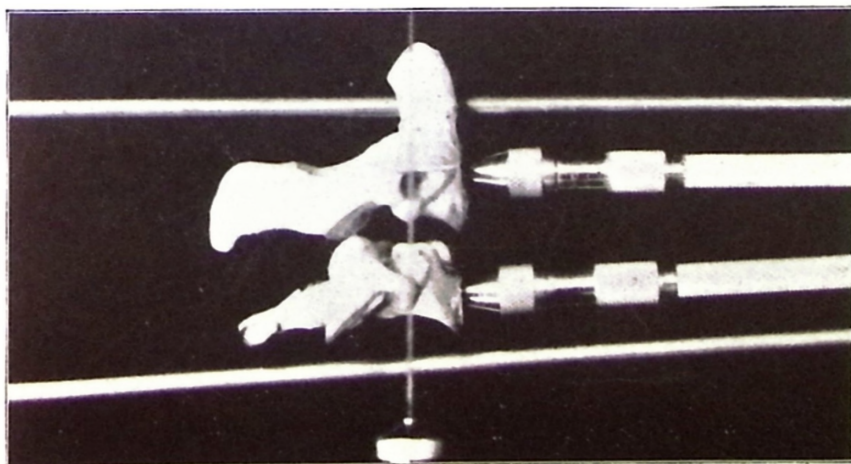


Fig. 171.

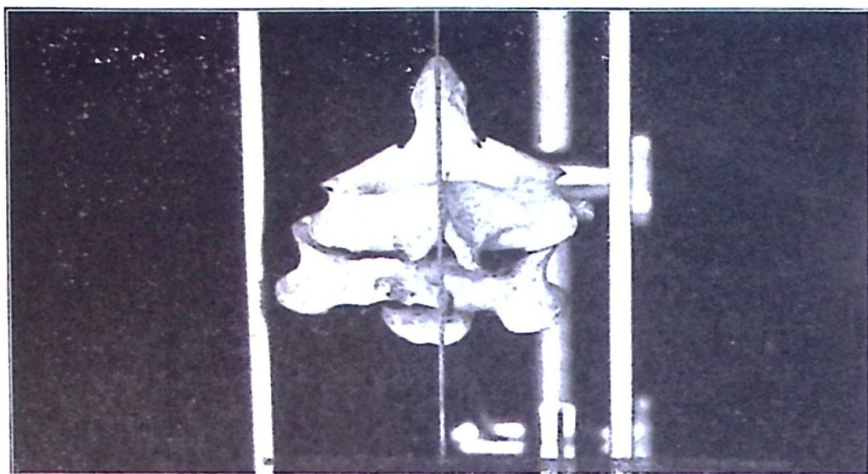


Fig. 172.

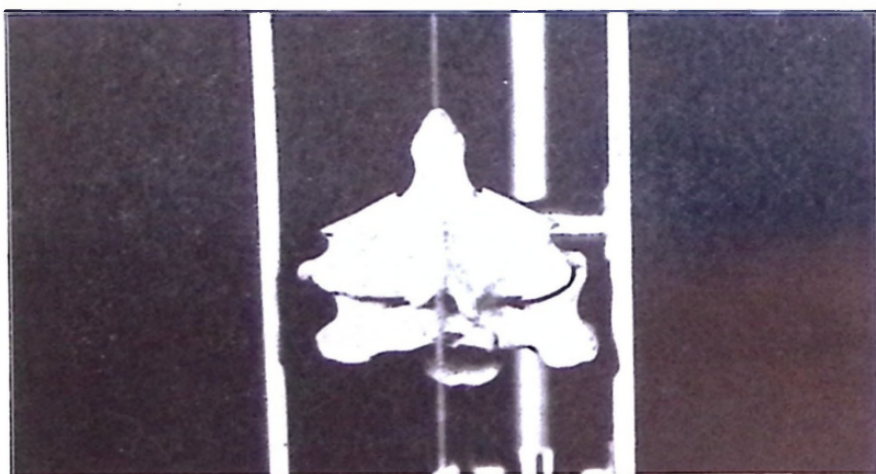


Fig. 173

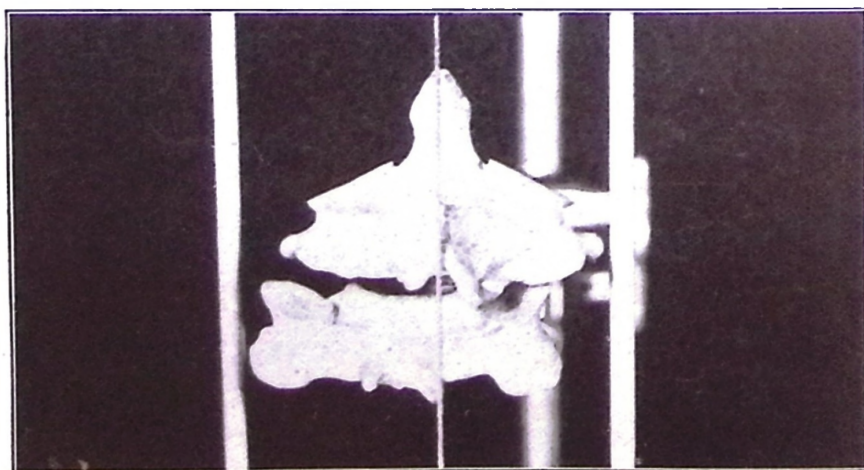


Fig. 174



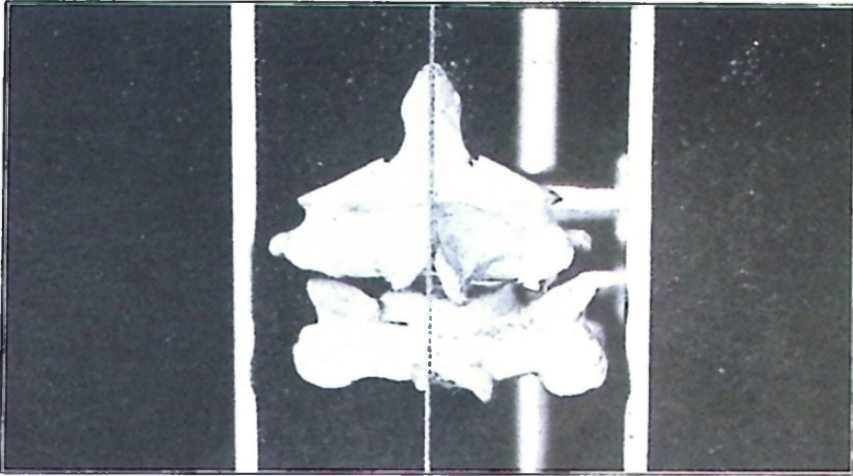


Fig. 175

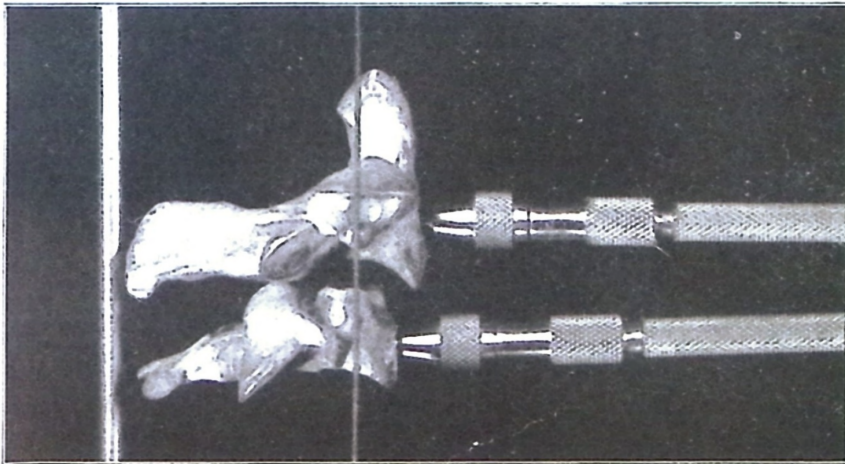


Fig. 176

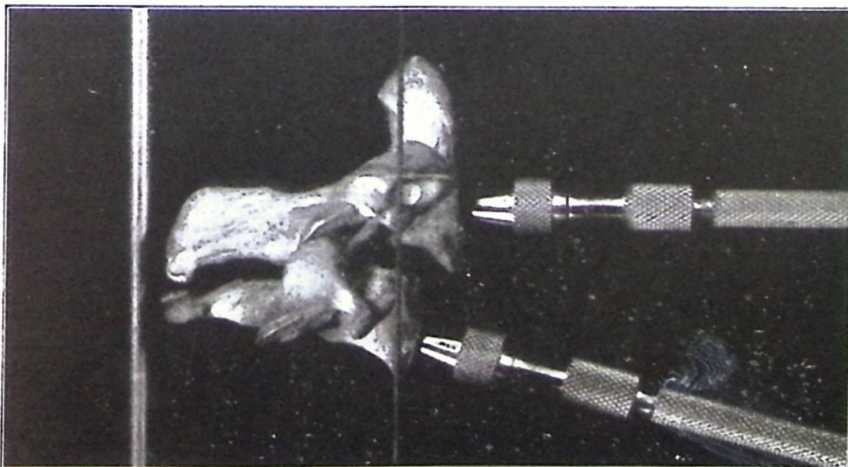


Fig. 177



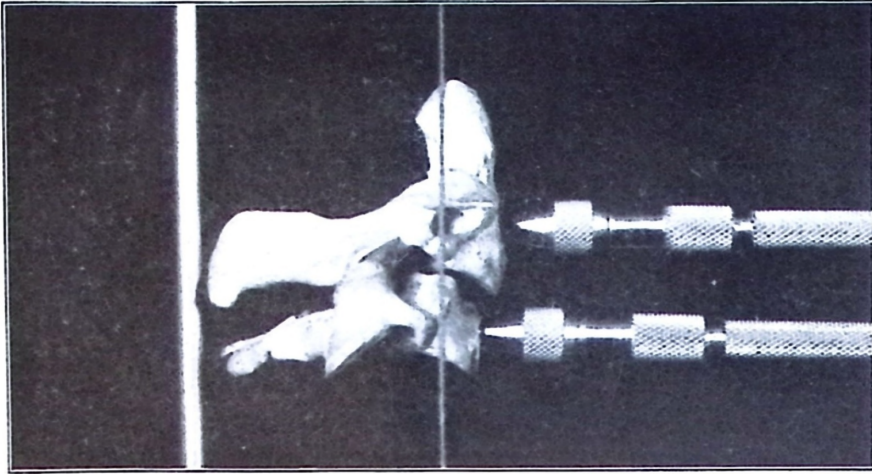


Fig. 178

ever found without a combination, therefore the above rarely exists.

Fig. 177. In this instance encroachment would be upon the superior foramina, pressure being upon nerves having their exit here.

Fig. 178. This would be the opposite to Fig. 177.

#### 7. *How and What makes Pressures..*

In the illustrations just given and the "pressures" spoken of, we wish to emphatically state that it is the permanent crushing or squeezing force of the two composite movable portions of the vertebrae, which, by their coming together make this opening acutely or permanently smaller, thereby impinging the *nerves* that pass through that exit, making lack of functions the constant feature.

#### 8. *Functions and Organs Involved. Location of—*

The tissues mostly involved by the ramifications from this exit are the fleshy portion of the neck. The teeth, jaw, nose, cheeks, etc., will receive their fibres from this area. In many instances fibres will be found to extend to the upper shoulder and possibly into the head. On rare occasions the nerve conveying impressions of sight to the mind and known to Chiropractors as "the optic nerve" may be impinged between 3rd and 4th cervical.

9. *Adjustments necessary to Correct each.*

Fig. 166. and 167. According to palpation are normal.

Fig. 168. Left subluxation would need the adjustment directly to the right as the patient lies with the head upon right side the movement would be a 45 degree angle of anterior and to the right.

Fig. 169. This subluxation is the reverse of Fig. 168 therefore would be given in an antipodal manner.

Fig. 170. In adjusting the 3rd cervical in this position the force would be given on the spinous process to the inferior.

Fig. 171. This subluxation is in common with the one above, only its opposite, therefore adjustment must vary accordingly.

Fig. 172. In this condition we have a combination abnormal position to the left and superior. The movement necessary to correct this is to the right inferior.

Fig. 174. In this we have the opposite of Fig. 173. Fig. 173 should be half way where Fig. 173 is now or vice-versa.

Fig. 175. This is a simple subluxation and must be corrected accordingly to the anterior.

Fig. 177. The force is to inferior and anterior.

Fig. 178. The reverse, or superior and anterior.

10. *How to give adjustments correctly.*

With the head lying upon either side it is a difficult matter to always prominently feel the spinous process of the 3rd cervical. In watching the position of the head, even when patient is prone, drop the head forward as far as it is reasonable, without inconvenience or suffocation to the patient. This will, in the majority of cases, assist in bringing to the surface this process. With the head dropped to one or the other shoulder, while prone, adjust it according to your analysis, being careful not to allow the head to be jerked forward, in which instance you would undoubtedly do more damage and create injury.

11. *What means and portions thereof to use.*

The same portions of the hand applies equally as well to the 3rd cervical as those we have already thoroughly described under Axis.

12. *What diseases to adjust the third cervical for.*

Many types of diseases of the head, neck and shoulder regions are found from subluxations of the 4th cervical, but this may vary in a small proportion of these cases, especially so when the 4th cervical inferior nerves emit from the superior of the vertebra and the subluxation be of the 3rd cervical, producing the pressures between the inferior notches of 3rd and superior of 4th. "Neuralgia" of the face, teeth, jaws, gums, etc. Dull headaches, full, heavy feelings in the head, colds of the head, catarrh of the nose and head, flushing or blushing face, cancers, polypi or tumors of the nose, cheeks, or lower jaw; serodoema of the glandular tissues of the neck, etc., etc.



## CHAPTER 7.

## FOURTH CERVICAL.

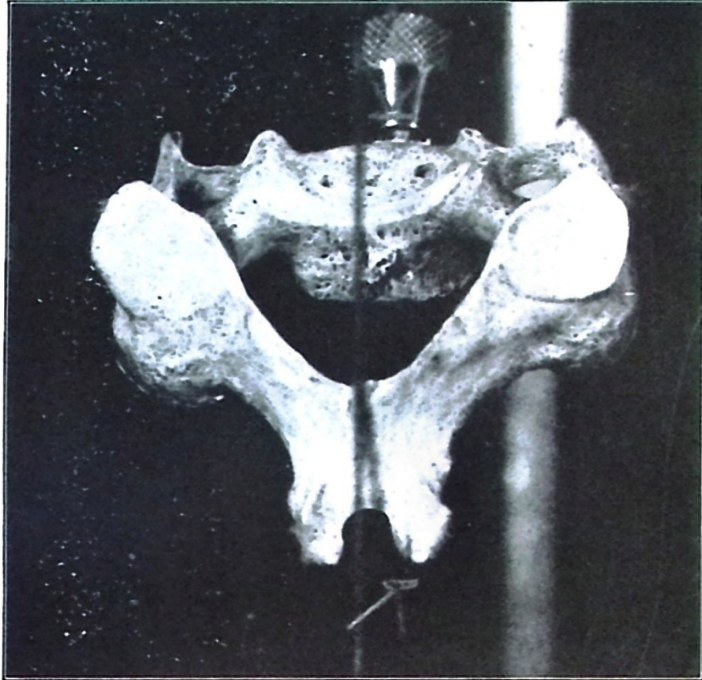


Fig. 168

1. *Vertebra and its title. M. C. P.*
2. *Superficial palpations and land marks.*

The bifurcations of processes, in the cervical increases from above downward until the 4th is reached. From there, downward, it decreases. This would tend to make the fourth more prominent. Fractures are quite common at this location. Owing to its being lower; its spinous process longer at the prongs and more divided, it can be readily and freely palpated especially when the head is dropped forward upon the chest. The nearest land-mark is the Axis spinous process. By counting from this inferiorly we are always certain of the exact number. Beginning at the 7th and working superiorly is very questionable in exactness and not to be tolerated with your clinical patients.

---

Fig. 169. Showing three lines to represent the positions of where spinous processes are beneath, with fingers on median line.

Fig. 170. Head flexed forward. Right latero-posterior position. Three fingers, one on each spinous process. Normal positions.



Fig.169



Fig. 170

### 3. *Normal position and articulations.*

Its normal position should be in connection with the articulations of the superior and inferior vertebrae. It has the same number of articular surfaces as contiguous vertebrae. The spinous process and the centrum should be based upon certain median lines, viz:—the horizontal, laterally perpendicular and the antero-posterior.

### 4. *Subluxations, described and illustrated.*

Subluxations of the 4th cervical are in common, as regards its characteristics, with those of the 3rd. The same kind, position and abnormality exist here as there.

The proportion of subluxation of this vertebra is much greater in degree and they occur oftener than in any other cervical excepting the Atlas.

Remember the neck is, as it were, a tube. The majority of the connections are with the expansions at each end, viz;—the superior with the skull; the lower firmly implanted and braced by the shoulders.

It is true, there are strong attachments between skull and shoulders but proportionately the intermediate spaces are weaker and have not the strength that either end may have. This fact, in connection with the knowledge that the center of rotation or mobility of the neck is at the 4th cervical and that when the neck turns itself the 4th is the central point of the lower holding fast and the upper turning, we can account for the larger majority of subluxations, as enumerated above. It would be superfluous to again illustrate what has once before been gone over, for the illustrations of subluxations of this vertebra refer to 3rd cervical, bearing in mind the above variations from the preceding illustrations.

### 5. *Relative positions of adjacent vertebrae.*

As already stated the relative positions would be greater and farther apart in subluxations of this vertebra than in any other cervical.

### 6. *Where nerves are impinged.*

In this instance, as in preceding, the pressure takes



place as nerves are passing through the foramina, by the occlusion of its size and shape. This modifies the opening by decreasing its caliber. The 4th cervical is adjusted very frequently and when subluxated the pressures are usually located upon the inferior of this vertebra. If the greatest mobility of the cervical centralizes around this vertebra, the most precise spot would be on its inferior surface.

7. *How and what makes pressures.*

In such conditions as we have previously portrayed, the pressure is invariably of a hard upon a soft substance. The intervertebral foramen is a movable opening and is subject to being made larger or smaller. The nerves, veins and arteries are the only substances that pass in exit or adit.

Nerve fibres are continuous from brain cell to tissue cell, or vice versa; have no anastomoses, therefore pressure upon them makes direct, partial or total stoppage, of mental impulses. The veins or arteries have most ample and complete anastomoses, even to the capillary circulation; pressure upon these as they pass in or out through these channels would not interfere with the circulation as the blood stopped would have but 1-500 of an inch to back up to find another channel for its passage. The Chiropractor has nothing to consider as being damaging *if* blood capillaries *should be* impinged. It would immediately transfer to some other point and leave the tissues as readily as before the subluxation.

8. *Functions and organs involved. Location of—*

The functions involved are characteristic of those found throughout the system. There being seven primary, they may be mixed into endless combinations. The location of the latter is confined to the head, neck and upper shoulders. Nerve tracing has, on rare occasions, gone lower in the upper chest or superior back region, these functions being usually superficial, although many are deeply imbedded.

9. *Adjustments necessary to correct each.*

The frequency of subluxations of the 4th cervical

would lead us to palpate this following the Atlas, if the latter was normal. The same kinds of subluxations would necessitate the adjustments as enumerated under 3rd cervical. The spinous process being more prominent makes it easier to adjust.

It will be noticed that the coat is removed in all views shown in this volume. We do not wish to convey the idea that palpation or the giving of adjustments is *work* but rather to give more freedom and less bothering with cuffs, etc. This art is easily accomplished, therefore this suggestion, to correct what might have otherwise created a wrong impression. 100 adjustments in an afternoon is considered a nice afternoon's diversion. The record stands when the author of this volume adjusted over 200 daily for 8 consecutive weeks.

10. *How to give adjustments correctly.*

With the head upon the side and slightly dropped toward the chest the 4th spinous process stands in view prominently. The adjustment should be directed to a 45 degree slant, inasmuch as it is at the center of the quarter circle curve previously spoken of. The greater movability of this joint, as a rule, makes it easier to adjust.

11. *What means and portions thereof, to use.*

The same portions of the hands are used here as are spoken of in a pervious chapter and is general to all cervical.

12. *What diseases to adjust the fourth cervical for.*

Many general diseases of the superior region are adjusted for at this vertebra. We have previously enumerated the reasons for the frequency of subluxations at this point. Headaches of the dull aching quality and usually those confined to the center third of the head from anterior to posterior, toothache in any portion, nosebleed or nasal hemorrhages upon either side, wryneck, torticollis, osteomalacia of cervical vertebrae in the majority of cases have their start by subluxations at this point, contracted muscles of either or both sides, front or rear. Strabismus is

rarely, but occasionally found at this location, but must be determined by nerve tracing.

All optic nerve affections, those where the functions of sight, including the sense fibres, are involved by nerves passing outward between 4 and 5 as a general rule. Now and then they proceed from above the fourth vertebra. Catarrh of the head including that of the nasal chambers and Eustachian tubes have their common origin by pressures upon nerves passing between these vertebrae.

Serous circulation locally confined to the neck, head and upper shoulder region also receives its mental impulses through nerves emitting at these points.

Cancers or tumors of the eyes, lips, either cheek or forehead.

Lupus of the nose, internal or external, would have its primary abnormal chemical functions interfered with by a mechanical subluxation at this point.

Now and then, as tracings must determine, arm affections, of various characters and degrees will develop due to subluxations and consequent pressures on nerves inferior to 4th.



*CHAPTER 8.*  
**FIFTH CERVICAL.**

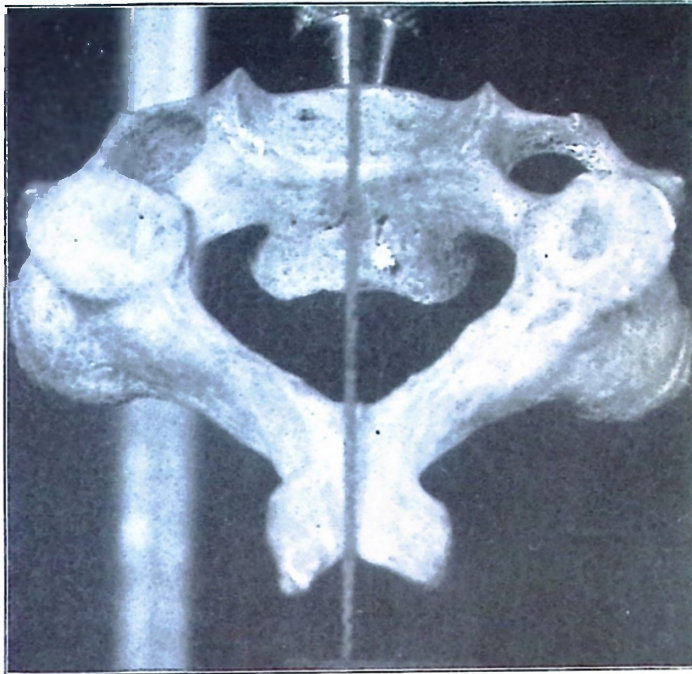


Fig. 171



Fig. 172

1. *Vertebra and its title. M. C. P.*

2. *Superficial Palpation and land marks.*

Subluxations of this vertebra are not as common, nor are fractures, as the one preceding, although they occur oftener than the average person is aware, and more often than the ones below it.

Fig. 172. Showing four lines with 1st, 2nd and 3rd fingers on lines underneath which are the spinous processes of the 4th, 5th and 6th cervical vertebrae.

In passing downward from 4th to 7th, each succeeding spinous process becomes larger and more prominent, therefore the 5th is in every respect palpated with less exertion and is often observable with the eye when the neck is anteriorly flexed. The landmarks are similar to those of the preceding. Count downward from the 2d or Axis spinous process thus determining its exact position.

3. *Normal position and articulations.*

Its normal position may always be determined by palpating carefully and should necessity arise you can begin to feel the transverse processes at about this area, it being almost impossible to exactly palpate the transverse of the cervical superior to this (unless the person be quite emaciated) with the exception of the Atlas. By comparing the transverses with the spinous and then that position in relation with the median line, you will have no difficulty in determining its *exact* position. This vertebra has the number and same locations of articulating surfaces and articulations that are common to the majority of cervical vertebrae.

4. *Subluxations, described and illustrated.*

Subluxations of the 5th are not as common as those of the 4th. The mobility of the column decreases from the 4th downward. If this vertebra is subluxated you will find, in the majority of cases and determined by palpation, for tender nerves on either side, that the pressures are upon the superior surface as they emit through those intervertebral foramina. The subluxations are the same as those of 3rd cervical with the exception that they proportionately increase in severity from Axis to 4th and would not be so pronounced from that downward to 1st Dorsal. According to this, those of the 5th would not be on the average, as bad as those of the 4th.

5. *Relative positions of adjacent vertebrae.*

In the larger proportion of cases the superior vertebrae will be found to be more or less away from normal position while the inferior will be set and quite firm upon their articulations, therefore the heads that are held to one side or the other can be analyzed usually with subluxations greater, in the more movable parts, than in those of the lower where they are held firmly upon their bases.

6. *Where nerves are impinged.*

Nerves can only be impinged in those parts of a cervical vertebra where there are and can be pressures upon nerves by bone. The study of a cervical vertebra usually shows that outside of the foramina, such is impossible unless there be direct fracture impinging some fibres; a condition which we could not avoid nor correct in the larger percentage of cases on account of their secreted position.

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Fig. 173. *Left* subluxation. Posterior view of 5th cervical showing pressure on left superior and left inferior foramina.

Fig. 174. *Right* subluxation of fifth cervical. Posterior view. Showing pressure on right superior and right inferior.

Fig. 175. *Superior* subluxation of fifth cervical. Showing pressure on right superior and left superior.

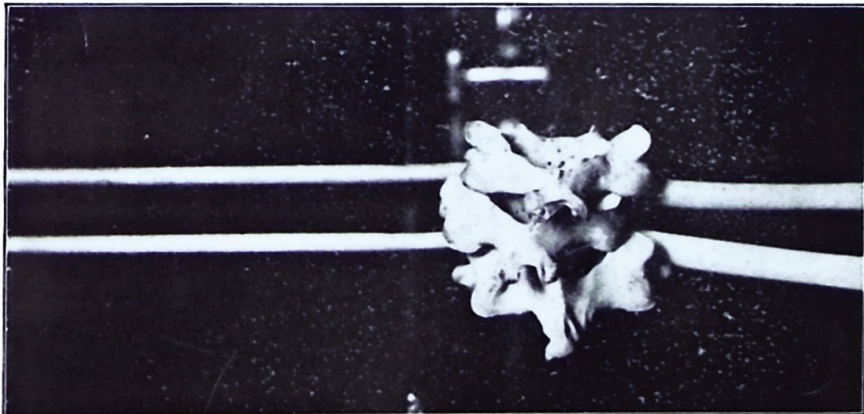


Fig. 173



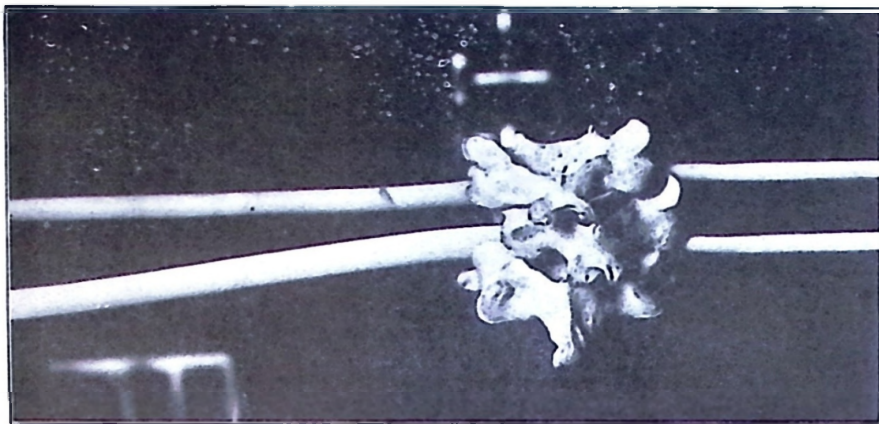


Fig. 174

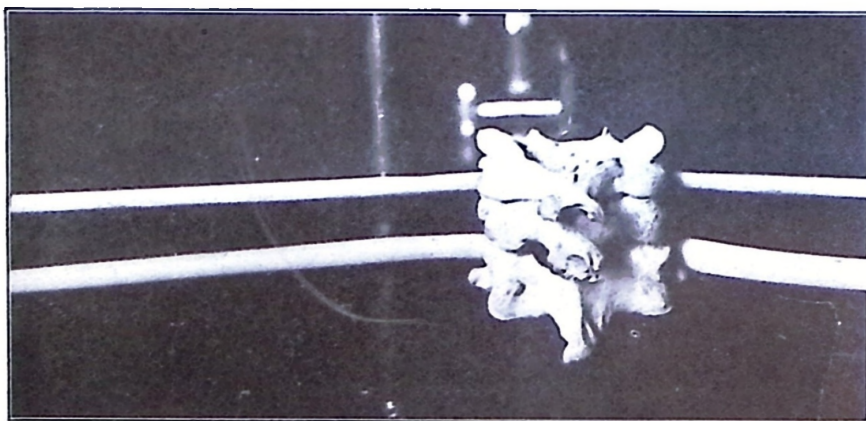


Fig. 175

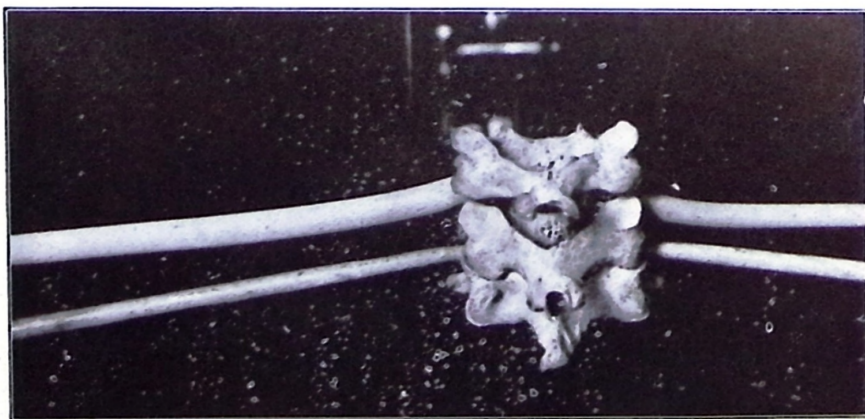


Fig. 176

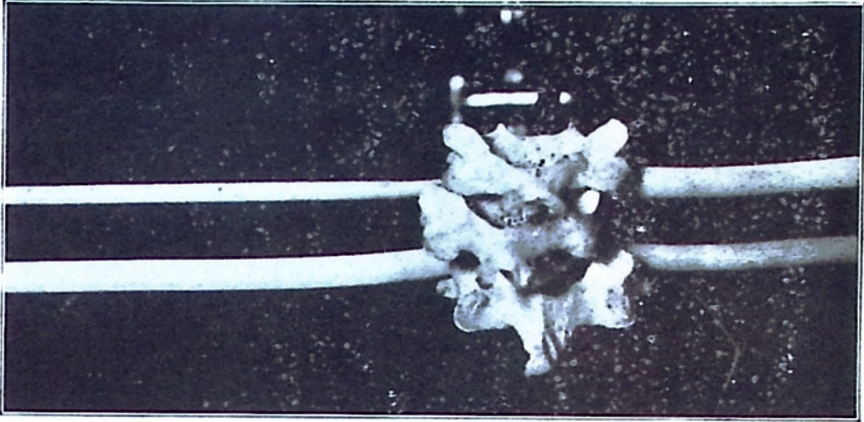


Fig. 177

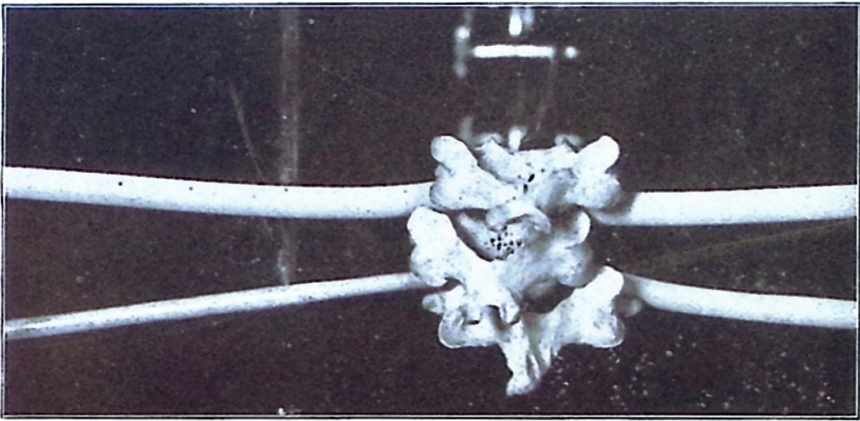


Fig. 178

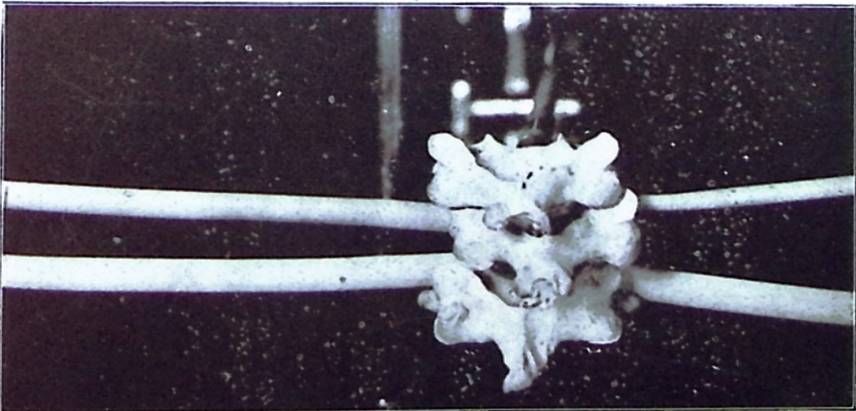


Fig. 179



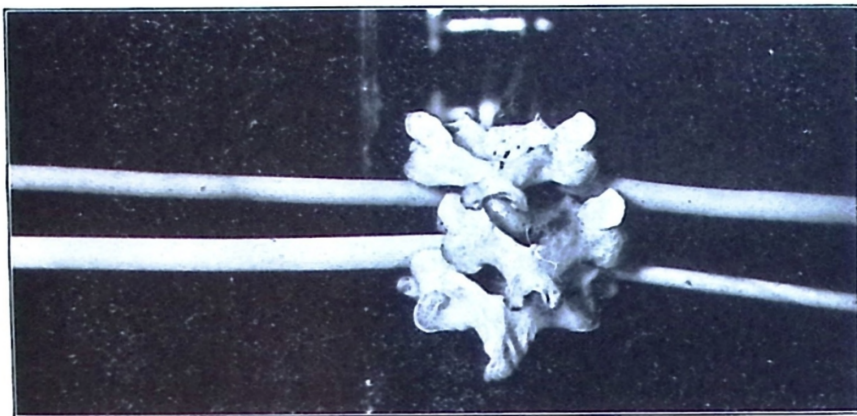


Fig. 180

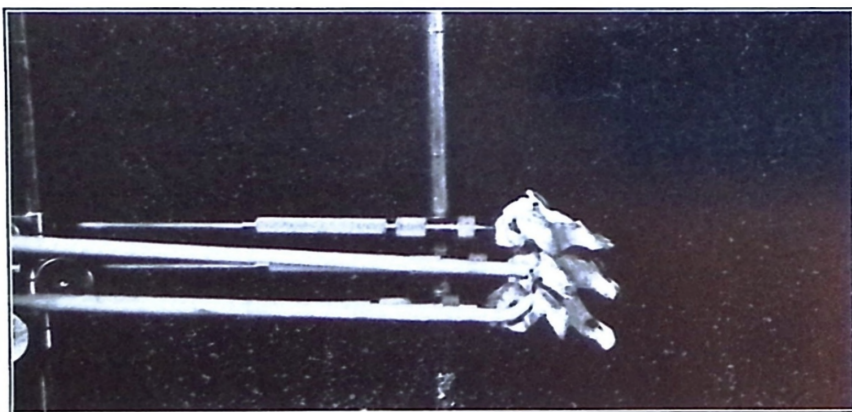


Fig. 181

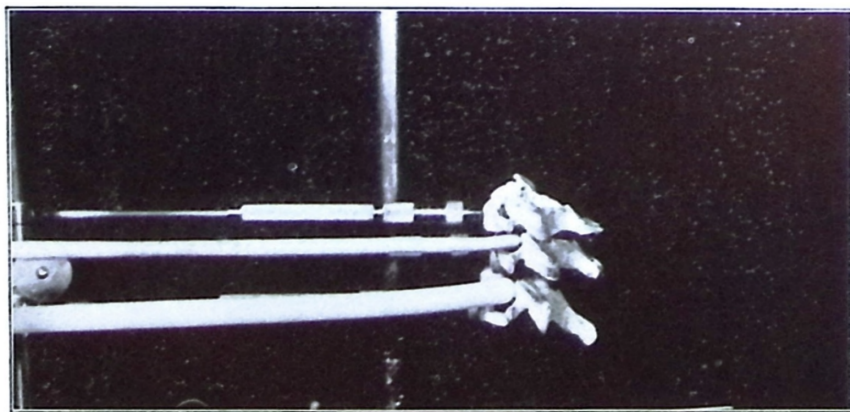


Fig. 182



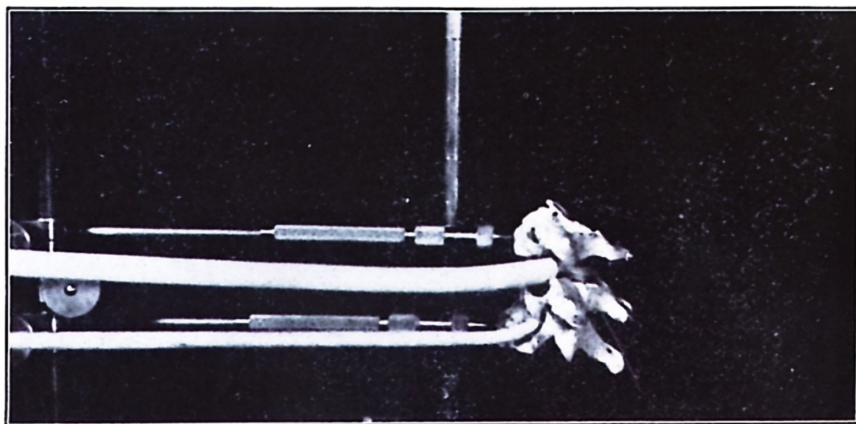


Fig. 183

Fig. 176. *Inferior* subluxation of fifth cervical showing pressure on left and right inferior.

Fig. 177. *Left superior* subluxation of fifth cervical, posterior view. Showing pressure on left superior.

Fig. 178. *Left inferior* subluxation of fifth cervical. Posterior view. Showing pressure on left inferior.

Fig. 179. *Right superior* subluxation of fifth cervical. Posterior view. Showing pressure on right superior.

Fig. 180. *Right inferior* subluxation of fifth cervical. Posterior view. Showing pressure on right inferior.

Fig. 181. *Posterior* subluxation of fifth cervical. Left lateral view. Showing pressure upon left superior and left inferior nerves. Foramina are decreased in size and shape.

Fig. 182. *Posterior superior* subluxation of fifth cervical. Left lateral view. Showing pressure on left superior.

Fig. 183. *Posterior inferior* subluxation of fifth cervical. Left lateral view. Showing pressure on left inferior.

#### 7. *How and what makes pressure.*

This has been carried under the preceding.

#### 8. *Functions and organs involved. Location of.—*

The functions affected by subluxations of this vertebra seem to be more limited than in the preceding but

such only becomes noticeable because of the fact that they are more limited in numbers of subluxations. The organs and tissues incorporated are fewer and farther between and even when abnormalities are manifest, their degree is less severe.

9. *Adjustments necessary to correct each.*

The adjustments are practically the same as preceding. Remembering that as the body rests in the prone position and head rests is upon the forehead the cervical makes as it were, on the posterior, a small valley having its highest points at the Axis and seventh, the 4th being the lowest.

As the head is rotated to one or the other side it still leaves this condition in a quarter rotary circle.

What may seem a minor point but must not be left out of consideration in every adjustment, especially in the cervical region, always adjust perpendicular to the plane and then vary slightly according to the way you intend to place the vertebra. Nothing is so hard to adjust and to *know* that you have adjusted correctly, as a cervical subluxation. To punch or to drive is not to correctly replace, and unless these items are taken into consideration together, you will have missed the most desirable and most important work to be accomplished upon the vertebral column.

10. *How to give adjustments correctly.*

To correctly give cervical adjustments, means that all these points must be accurately and thoroughly studied to make each of you a capable adjuster of such conditions. They are the principles upon which this mechanical, superior portion moves.

It cannot be too strongly impressed that each subluxation represents an individual abnormality so far as it is by itself. Years of Chiropractic adjusting proves that I have yet to find where it becomes necessary to adjust more than one vertebra at one time. The physical representative of the cause of each disease is a *direct, single* subluxation creating specific pressures upon

certain nerve fibrillae which must issue through an exact foramen. The great value of Chiropractic is its directness in all that pertains to scientific work. When you begin to get strangle holds on *several* vertebrae you are not correcting that *one* which needs it. In your palpation, tracing, adjustment, etc., bear in mind which vertebra you are hunting for, *one, not many*, and find it. The correction of that one will give all the results you will need providing you adjust it *just right*. Subluxations are the results of concussion of forces which center at some *one* point. It is *there* that the mischief is created, *there* is where your work is needed. True, the extent of the blows might be spread but be that as it may, *each* vertebra, if subluxated, is an individual unto itself and should be corrected as such. Do not attempt to correct two or three successive vertebrae at one time. Your aim is to set *one* upon its normal articulations, in apposition with the one above or below. To try and move the two that are affected, for the sake of display is poor policy and not practical with conservative Chiropractors who think more of results than of money.

11. *What means and portions thereof to use.*

The portions of the hands have been given in detail and must be utilized here as well as anywhere else. Without due consideration of these points of skill, a large proportion of your power is misspent making it compulsory to use greater diversified strength and less knack than you would do otherwise. The risk of injury in bungling work is great. *Concentrated forces*, skill and ability will be followed by greater results than attained in any other way.

12. *What diseases to adjust the fifth cervical for.*

The region involved by such is more limited than that of the 4th. Although now and then, we will trace fibres directly between 5th and 6th cervical.

The superior nerves are sometimes involved but not subject usually to any great degree of damages or interference. The area may be similar to that of the 4th only in rare instances, the zone would be proportionately lower.



## CHAPTER 9.

## SIXTH CERVICAL.

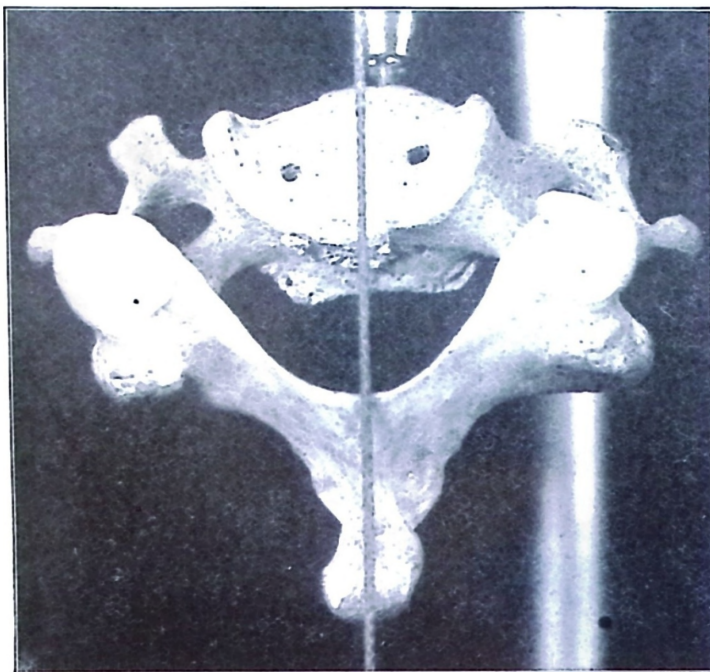


Fig. 184

1. *Vertebra and its title. L. C. P. or U. A. P.*
2. *Superficial palpation and landmarks.*

Proceeding inferiorly we find the processes getting longer therefore the sixth cervical is more prominent than all its predecessors with the exception of the Axis spinous process. Oftentimes this process is larger, longer and more prominent than the seventh which follows and it is only by the closest palpation that you will be able to determine one from the other. It is seldom that this process is bifurcated although that is common to the 5th.

In rotating the head the sixth will be found slightly movable although its motion is quite limited. The spinous process of this vertebra looms into superficial prominence and being at the superior portion of the shoulder is subject to many blows, which, while intended for the head, strike the shoulder region, instead. Fractures do occur although the vertebral process is stronger and more firmly fixed than most. Your consultation as regards past accidents ought to determine whether you need beware of such foolers.



Fig. 185. Showing 5 lines on neck, each of which is over a spinous process. 2nd, 3rd and 4th fingers are over the 5th, 6th and 7th spinous processes respectively.

3. *Normal position and articulations.*

Its normal position is determined by palpation and comparison with the spinous processes above and below, although if there be a fracture of this process it might fool you considerably. Fractures do occur in these regions and usually the patient is aware of the fact. Its articular surfaces and articulations are in points of number and position identical with those of the preceding, with the exception of the approach toward the characteristics of the dorsal.

4. *Subluxations described and illustrated.*

Fractured distal ends of the neurapophyses would fool an expert if he had not the knowledge of palpation of the transverse processes and location of tender nerves. One or the other or both will contradict the first. The subluxation, that is, its present abnormal position, can be determined by approximation of spinous and transverse processes and tender nerves on either side. All three can be

abnormal but if the spinous is abnormal and the other two fail to show peculiarities, you may conclude that this vertebra is normal.

Subluxations of the 6th cervical occur less often than those of the 5th. The kinds therefore are similar to those of superior vertebrae but on the whole not as great nor the consequences as severe as those of the 5th.

5. *Relative positions of adjacent vertebrae.*

Answered under point 3 of this chapter.

6. *Where nerves are impinged.*

The majority of pressures upon nerves in consideration of this vertebra, is as they pass through the intervertebral foramina on the *superior* surface. Occasionally nerve tracing will determine the pressure on inferior between 6th and 7th.

7. *How and what makes pressure.*

On the degree of subluxation depends the quantity of

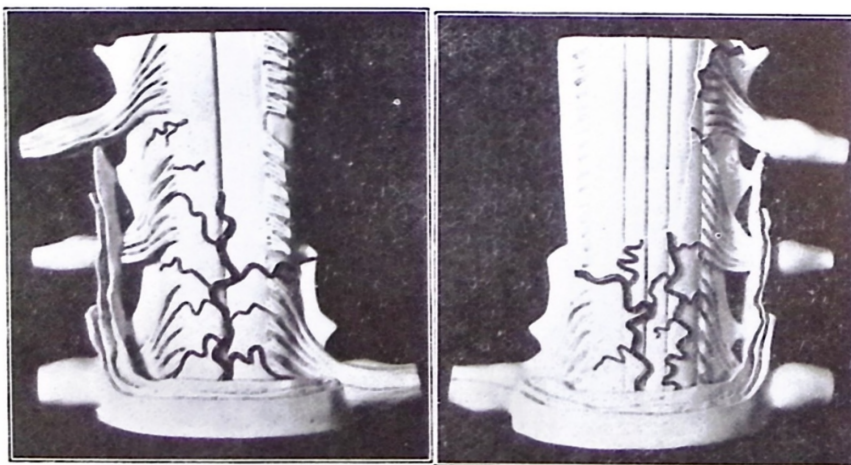


Fig. 186 Enlarged portion of spinal cord. *Anterior* view. Showing how nerves emit from the cord and pierce the sheaths. Wax model belonging to *The P. S. C.* 186 does from opposite side. Osteological Collection.

Fig. 187. Enlarged portion of spinal cord. *Posterior* view. Shows all that Fig. 186 does from opposite side.



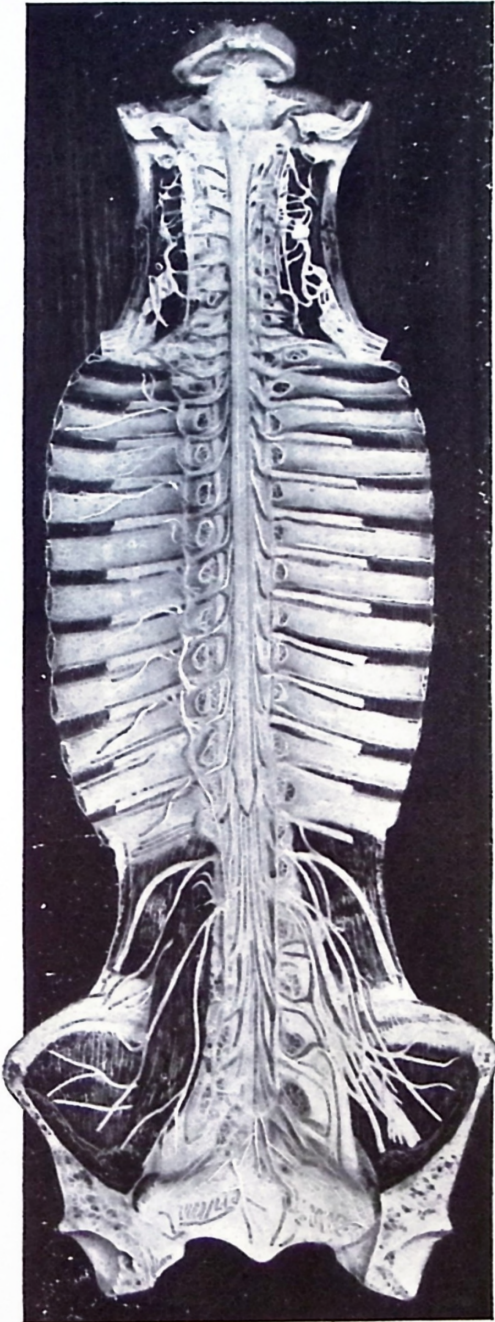


Fig. 188. Enlarged model of spinal cord and torso. Shows where nerves emit from spinal cord. Wax model belonging to *The P. S. C. Osteological Collection*.

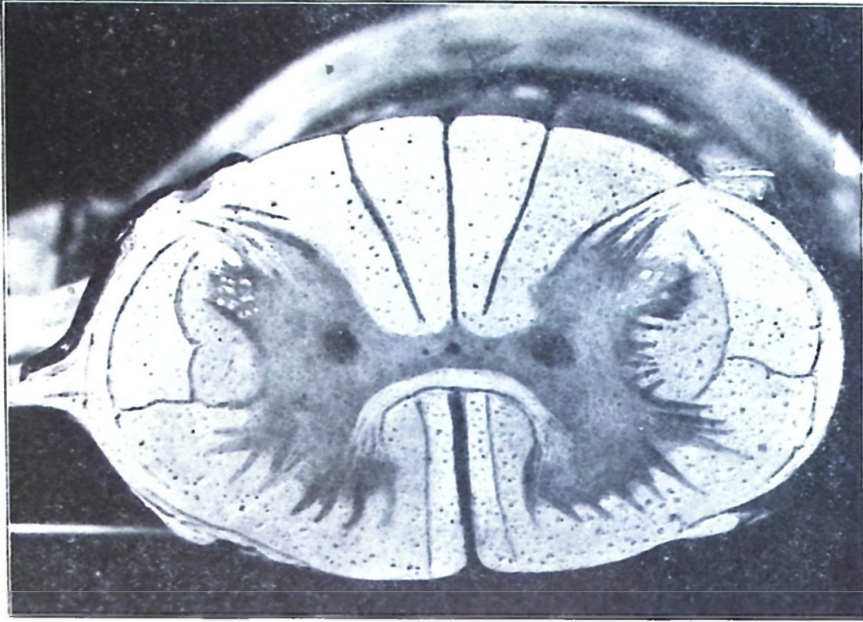


Fig. 189. Enlarged view of sectioned end of spinal cord. The superior surface of Fig. 186 very much enlarged.

pressure and the consequential lack or excess of quality of expression at peripheral. The character of the disease being entirely dependent upon the degree of impingement and the combination of functions involved. The pressure is the result of the compaction of solid or osseous-structures around and upon the compressible nerves.

8. *Functions and organs involved. Location of—*

In a few cases, as investigation leads us to believe, throat difficulties are and can be traced directly to the 6th cervical. Also some types of a dull, languid headache. Aching and contracted muscles of the shoulder and upper pectoral, humeral regions are involved likewise. In brief, we might say that affections of shoulders, throat and head are produced by subluxations in this region, although not as often as in the previous cervical. The abnormal functions are such as are common to all tissues.

9. *Adjustments necessary to correct each.*

The adjustment in each instance depends entirely upon *how* the vertebra is subluxated. If I find one common fault with students, it is that you do not study the approximation principle closely enough and even when



found and analyzed you do not study the proper placing of your hands to give the movement in the right direction. This is a most important feature of Chiropractic adjusting. Too much stress cannot be laid thereon. You reason, perhaps foolishly, that because your teachers observe these conclusions quickly, that you can do likewise, but you overlook the fact that experience makes ease and facility. It makes and gives speed with piece work. He who has palpated spines for years, doing so with the accurate plan of work as outlined in this book, observes, feels, reasons and makes deductions, very quickly and accurately. Students, studying principles of adjusting, must not forget that you are only beginning to advance; *weigh each thought and movement*, position of each hand and of your body; how you will give the force and every one of your essential eleven points must be considered. When adjusting your patients be not in too great a hurry. Time is precious but results more so. Analyze each subluxation and adjust it accordingly.



Fig. 190



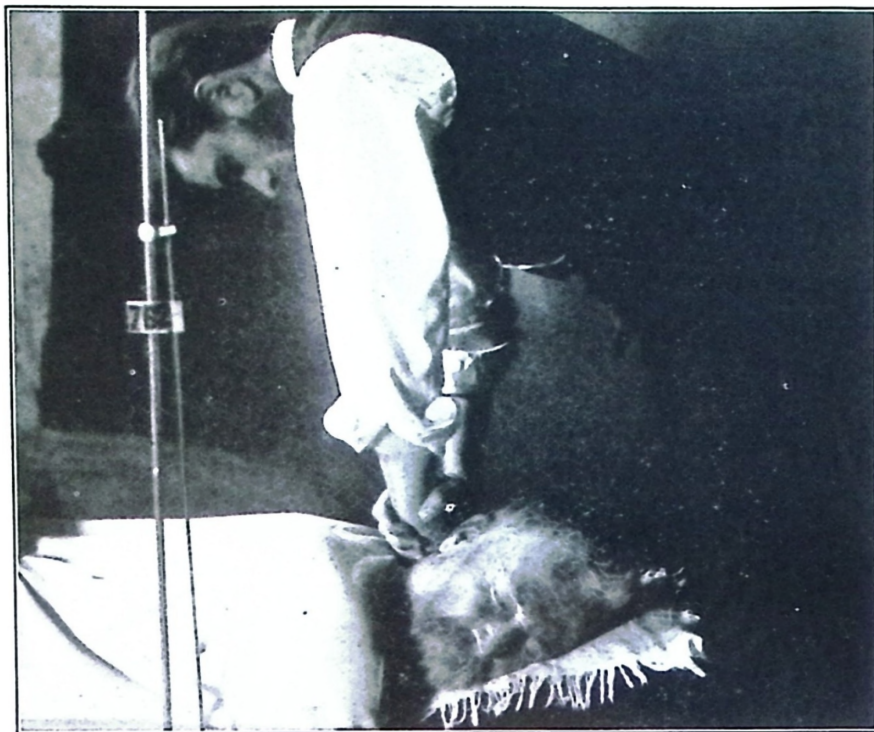


Fig. 191

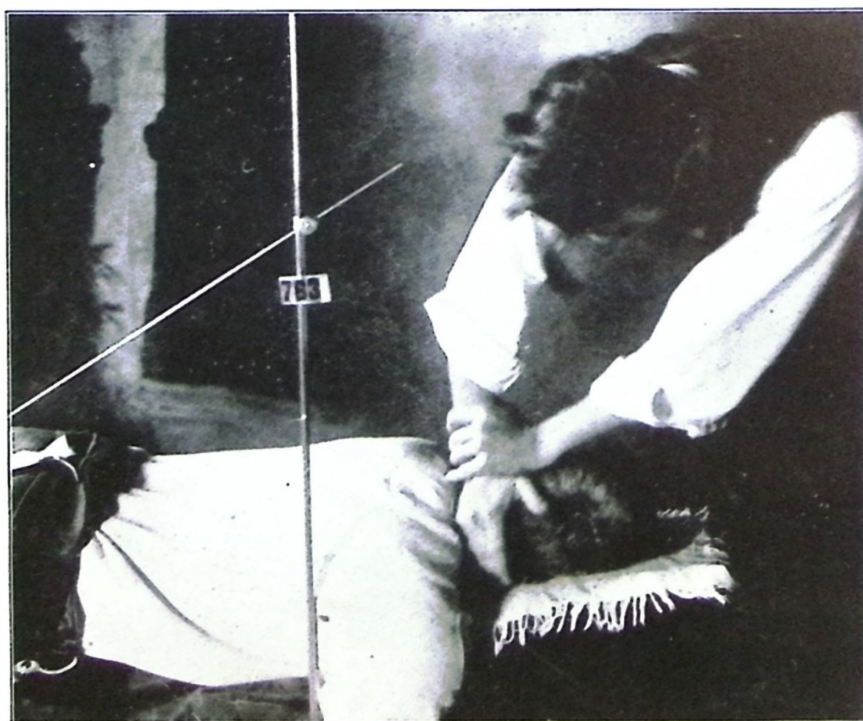


Fig. 192

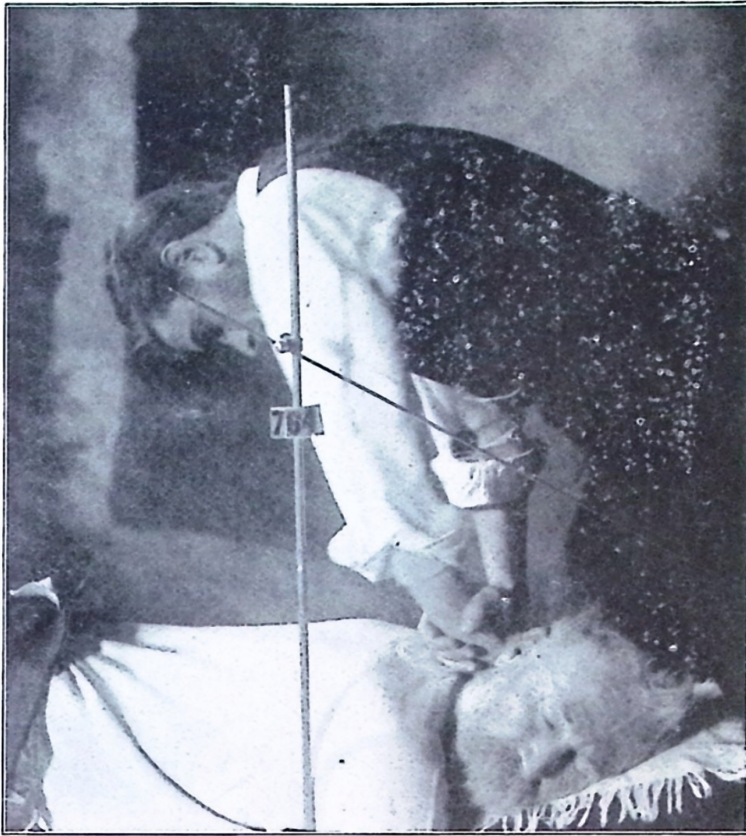


Fig. 193

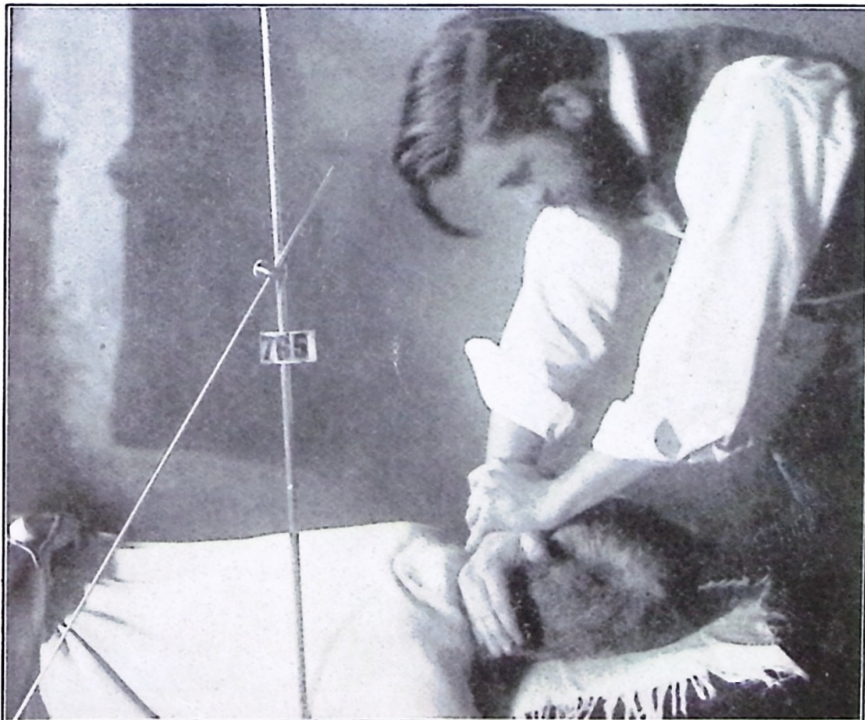


Fig. 194



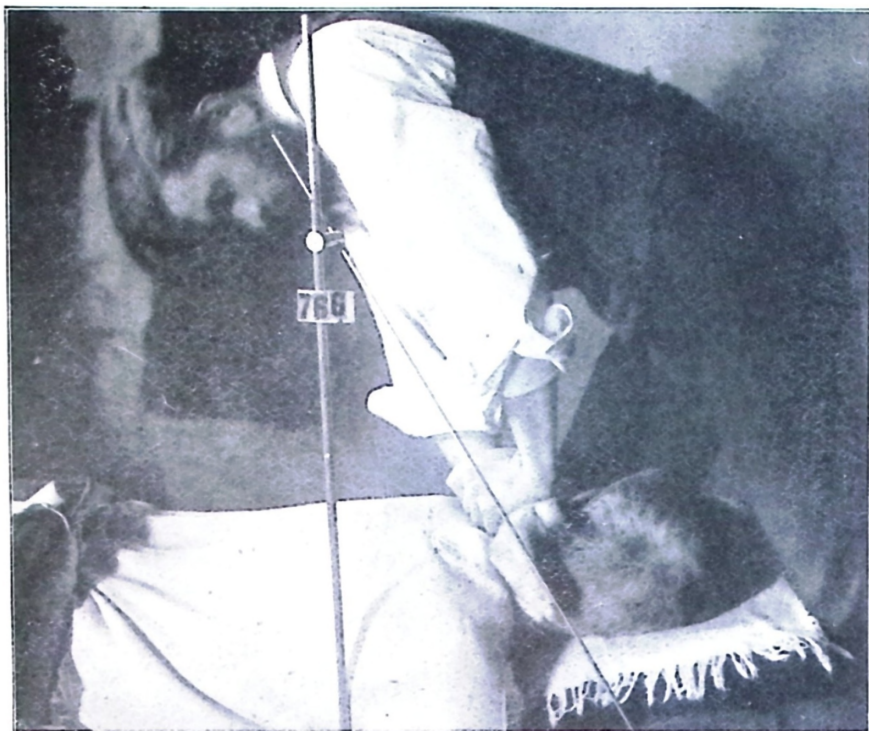


Fig. 195

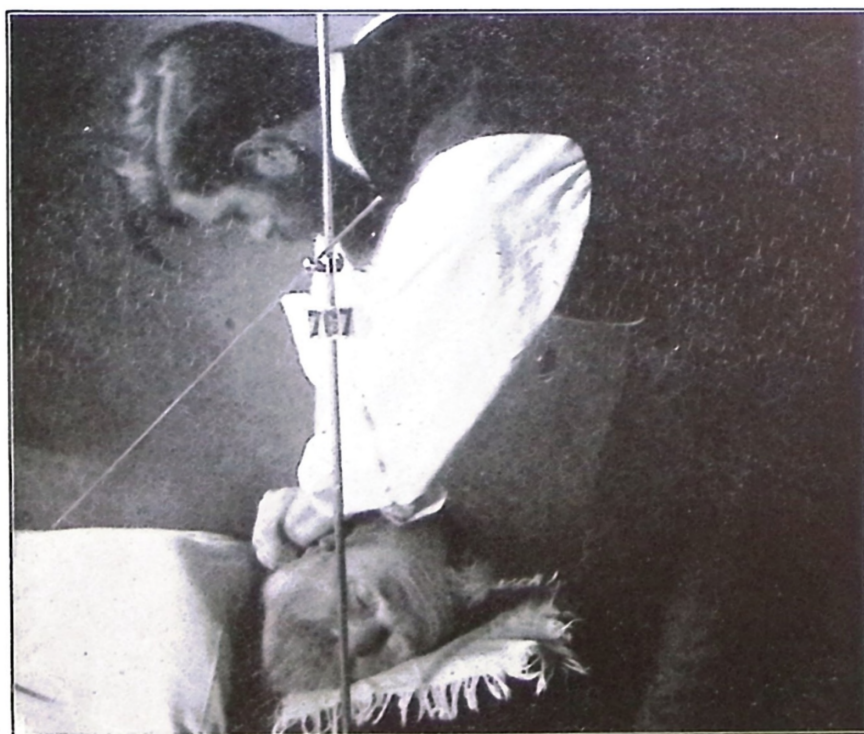


Fig. 196



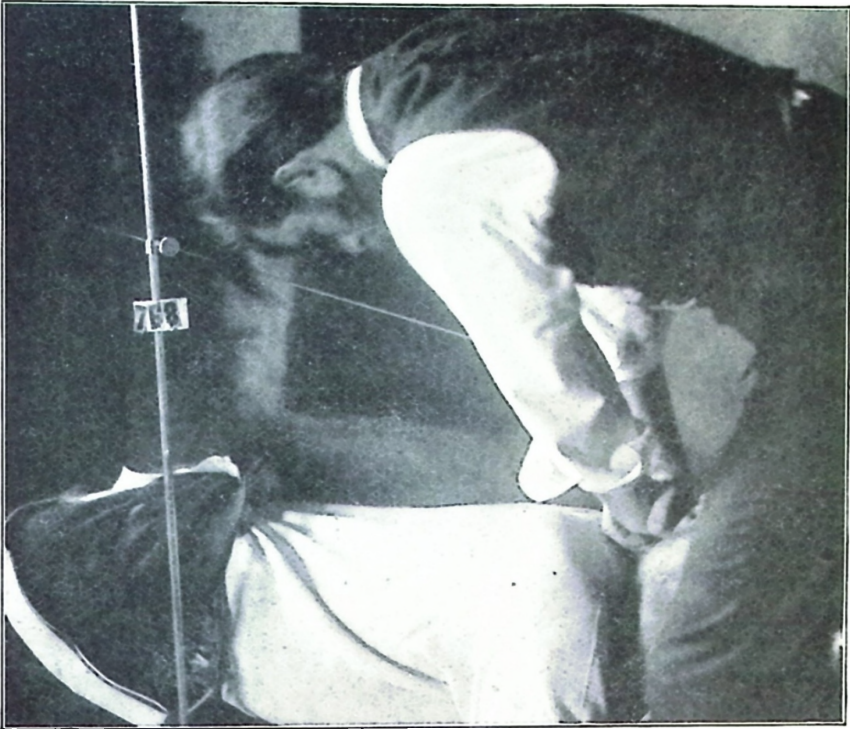


Fig. 197



Fig. 198

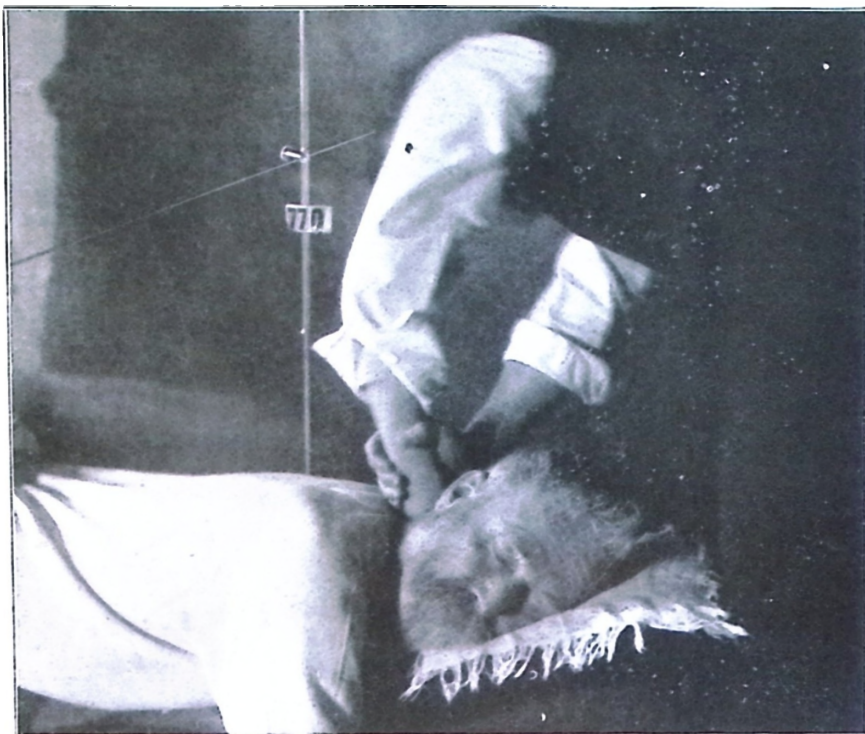


Fig. 199



Fig. 200

10. *How to give adjustments correctly.*

Fig. 190. *Left* subluxation of sixth cervical. Adjustment given *standing at head*.

Fig. 191. *Right* subluxation of 6th cervical. Adjustment is to left. *Standing at head*.

Fig. 192. *Superior* subluxation of 6th cervical. Right lateral view. Adjustment is inferior as indicated by pointer. *Standing at head*.

Fig. 193. *Inferior* subluxation of 6th cervical. Right lateral view. Adjustment is superior. *Standing at head*.

Fig. 194. *Left superior* subluxation of 6th cervical. Adjustment is *right inferior*. Adjustment given with *adjuster standing at the head*.

Fig. 195. *Left inferior* subluxation of 6th cervical. Adjustment is *right superior*. Adjustment given with *adjuster standing at head*.

Fig. 196. *Right superior* subluxation of 6th cervical. Adjustment is *left inferior*. *Adjuster standing at head*.

Fig. 197. *Right inferior* subluxation of 6th cervical. Adjustment is *left superior*. *Adjuster standing at head*.

Fig. 198. *Posterior* subluxation of 6th cervical. Adjustment is *anterior*. *Adjuster standing at head*.

Fig. 199. *Posterior superior* subluxation of 6th cervical. Adjustment is *anterior inferior*. *Adjuster is standing at head*.

Fig. 200. *Posterior inferior* subluxation of 6th cervical. Adjustment is *anterior superior*. *Adjuster is standing at head*.

11. *What means and portions thereof to use.*

In addition to the above you cannot be too careful to properly place the hands so as to get the greatest concussion of forces from your hands and arms with the least effort and labor. You must analyze and then focalize your actions.

Study the nail and hammer illustrations and see if you are complying strictly to its fundamentals. If not you



should immediately change. Certain parts of the hands are best; those which are used after years of experience. To change is commendable, should it prove advantageous. But less labor is required to hit a nail on its head with the hammer head than on any other place, with the object of getting the most results for the smallest expenditure of labor.

12. *What discases to adjust the 6th cervical for.*

This question was principally answered under Point 8. Any function of the region mentioned might and could be incorporated under this existing condition of things. To enumerate the diseases would be endless even though the 6th cervical has only a limited amount of them.

CHAPTER 10.  
SEVENTH CERVICAL.

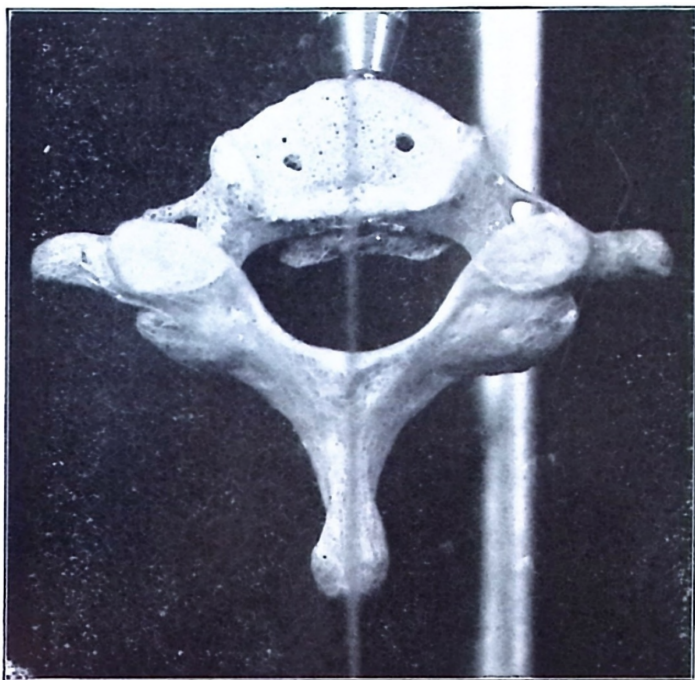


Fig. 201.

1. *Vertebra and its title.. V. P.*

The seventh cervical vertebra is the vertebra prominens, because of the comparatively greater projection of its spinous process, which serves as a distinctive landmark in this region. In rare cases the anterior root of the costo transverse attains a large size, it is then known as a cervical rib. The seventh cervical is one of the three peculiar cervical. (17-18).

If it be conceived that an individual be placed in the position of a quadruped, or rather that the limbs are separate and perpendicular to the trunk, the nerves emitting from the spine, assume the shape of circular bands or zones. The dermatomeres assume the form of circular bands arranged in strata. As regard the upper limbs, they are prolonged along its length in parallel bands, more or less regularly placed lengthwise, but one superior or in-

ferior nerve blends some of its fibres into the dermatomere above or below so that *one* nerve or the impulses transmitted thru it does not, alone, entirely control one zone.

This deposition of nerve fibres into zones commences with the atlas and ceases with the coccyx. The higher the vertebra and its corresponding nerves the more elevated is the zone that it usually separates into.

Brain expands cells into fibres which prolong into the spinal canal, form the spinal cord, give off branches, which emit thru intervertebral foramina, thus connecting the place of exit with a definite, specific zone.

This fact alone is what has proven *The P. S. C.* study of the nervous system and its additional diagnostic feature, the greatest of its kind.

The above basic is proven in clinical work, every day, with the exception of the paths that vary from this which are mapped out and observable under Nerve Tracing. The latter feature of *P. S. C.* work has also made the paths of distribution and the determination of these zones a feasible proposition.

## 2. *Superficial palpation and landmarks.*

Placed at the junction of the neck and the upper back regions, its position is especially prominent and easily observed without hard palpation.

Although this is known as the "vertebra prominens" it is not uncommon to find the 6th cervical or 1st dorsal as large or larger. To be accurate count downward from the spinous process of the 2d. As has been said, the cervical portrays a hemispherical curve, and the 7th being placed at its base makes it, combined with the similar tho lengthened condition of the dorsal, the most prominent point of the spinal column. Of the spinal column, superior to the sacrum, it is the plainest landmark upon the normal spine.

## 3. *Normal position and articulations.*

With the exception of the sacrum no other vertebra can boast of having so many important ligaments, aponeuroses, and muscles attached to it and is so firmly in-



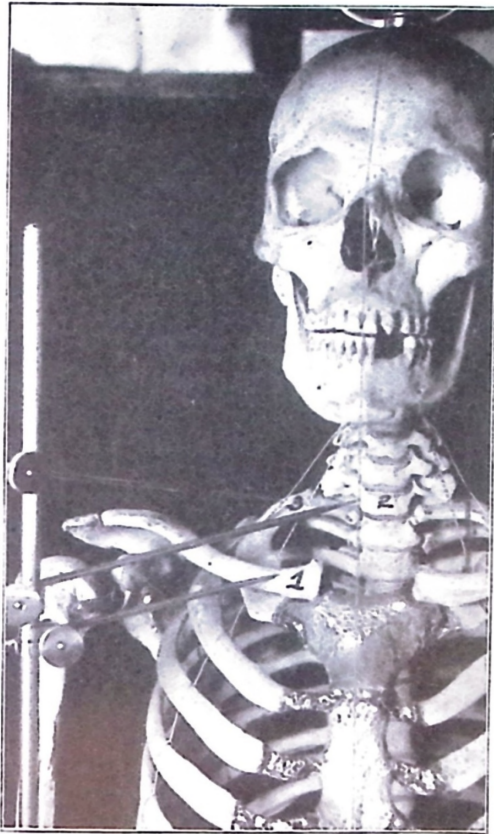


Fig. 202

Fig. 202. Enlarged *anterior* view of first rib, scapula and clavicle to show firm entrenchment of seventh cervical. 1 is clavicle; 2, anterior centrum of seventh cervical; 3 is 1st rib.

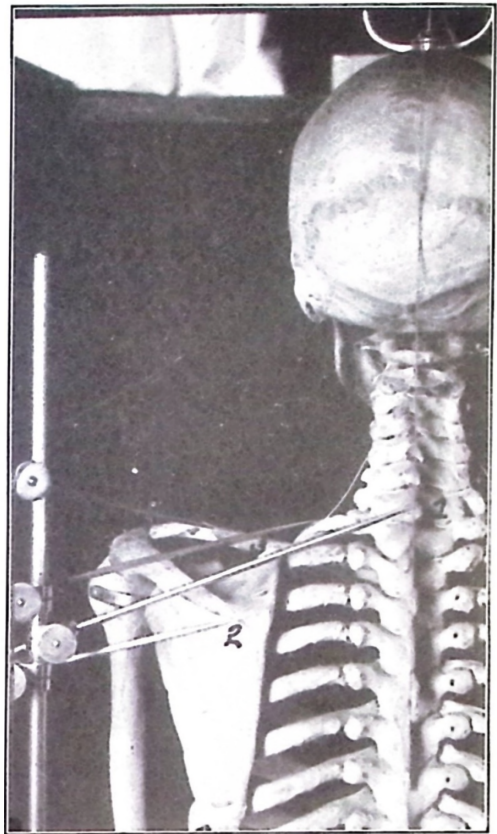


Fig. 203

Fig. 203. *Posterior* view of seventh cervical. Brings out similar ideas as Fig. 203 only posterior. 1 is posterior of seventh cervical; 2, scapula and 3 is first rib, rear view.

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trenched in its position as the 7th. It is lodged by the 1st rib, scapulae and arms, doing their greatest pulling from side to side from the center of its supports. Its normal position is thus very easily observed and consequently needs but little of our attention. It is seldom that diseases or their tender nerves are traced to this vertebra. It would be difficult to give an estimate of how rare such

are, because *The P. S. C.* has only had an extremely limited number of cases in which the 7th was involved.

So firmly is this rooted that in the majority of cases the processes will fracture and letve the centrum in original place.

4. *Sub-luxations, described and illustrated.*

Sub-luxations of the 7th cervical are so rare that detailed consideration will not be given. If such is found and you are certain, without a question of doubt, that it is creating damage, compare its position with what has gone before for they will be handled similarly.

5. *Relative position of adjacent vertebrae.*

The relative positions would be spoken of under 6th cervical for it is that which usually is abnormal in relation to the 7th. The Dorsal will give the inferior comparisons. The 7th is a fixed point or base for consideration of the cervical above and dorsal vertebrae below.

6. *Where nerves are impinged.*

If time be given to answering this we must consider it from a subluxation of 6th Cervical impinging from its inferior abnormal position or if there *appears* to be an inferior subluxation of 7th compare with Sup, of 1st Dorsal and you will arrive at the deductions which shows the latter the physical representative of the cause, not the former.

7. *How and what makes pressures.*

In this instance we have little to comment upon inasmuch as subluxations are rare, as has been stated previously.

8. *Functions and organs involved. Location of.*

See point 1.

9. *Adjustments necessary to correct each.*

See point 7.

10. *How to give adjustments correctly.*

If some violent accident happened and should fracture some of the strong supports for this vertebra and subluxation exists as a consequence, just remember that it needs adjusting and correct it by applying the same principles here as elsewhere. It being at the crest of the spinal ridge your adjustments would be directed anterior and varied from that according to the direction to correct.

11. *What means, and portions thereof, to use.*

This has been thoroly demonstrated.

12. *What diseases to adjust the seventh cervical for.*

Unless otherwise convinced, by unalterable evidence, this would be the last vertebra in the spinal column to be subluxated.



CHAPTER 11.  
THE DORSAL.

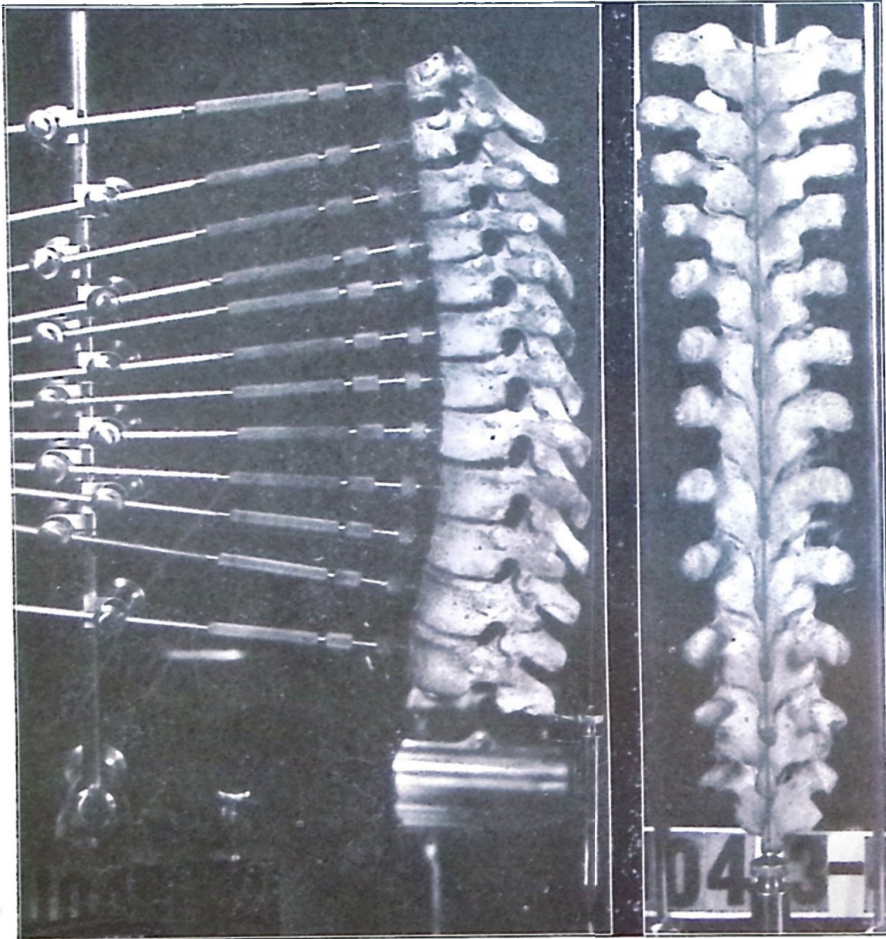


Fig. 204. *Left* lateral view of twelve dorsal. Shows foramina thru which brain nerves have passage from spinal cord to tissue.

Fig. 205. *Posterior* view of twelve dorsal. Notice the lineup of spinous processes when compared to the plumb line.

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The Dorsal, or more properly thoracic, vertebrae are especially peculiar for the facets upon the sides of their bodies for the articulations of the ribs, and for the length and obliquity of their spinous processes. The bodies in the



Fig. 205½

middle of the Dorsal series are as broad from side to side as they are from front to back, and are characteristically heart-shaped. They are generally thicker and concave behind, narrower and convex in front. On each side, near the root of the pedicle, there is a demi-facet above and below, these, when articulated with the adjoining vertebrae, form, with the intervening disk of fibre-cartilages, oval surfaces for the reception of the heads of the corresponding ribs.

The pedicles are directed backward, and the laminae overlap each other, the spinal foramen which they enclose being circular and smaller than in the cervical region. The articular processes are nearly vertical, and the costo-transverse processes arise behind them. The latter are of considerable length, are strongly developed, and present clubbed extremities, their anterior portions having concave facets for articulations with the tubercles of the ribs. The first and twelfth Dorsal vertebra, in general conformation, approximate respectively the last Cervical and first Lumbar vertebrae. The Dorsal vertebrae which have noteworthy differences are the first, second, ninth, tenth, eleventh and twelfth.

## CHAPTER 12.

## 1ST DORSAL.

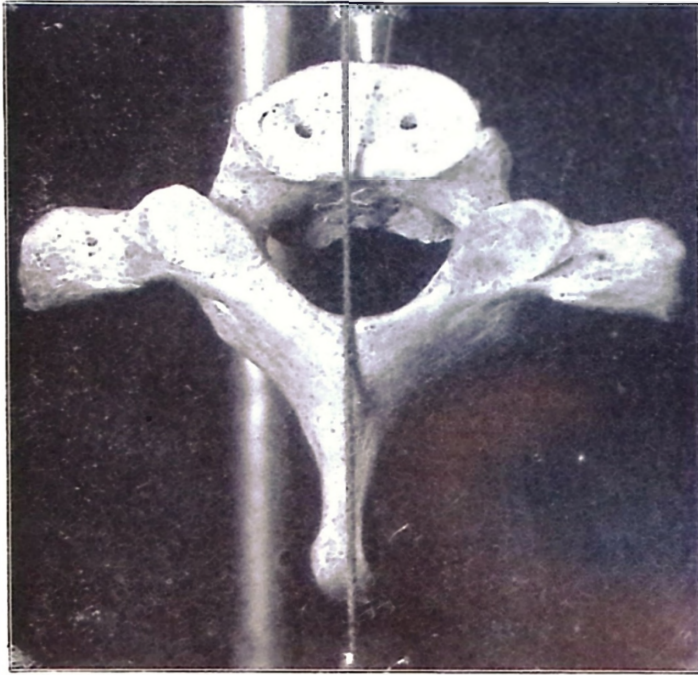


Fig. 206.

1. *Vertebra and its title, A. P. or H. P.*

The first Dorsal vertebra has a whole facet on each side of the body for the reception of the head of the first rib and a demi-facet below for the upper half of the head of the second rib. In other respects it resembles the vertebra prominens.

2. *Superficial palpation and land marks.*

Its proximity to the 7th Cervical makes it easy of location. Often times this spinous process is equally or more prominent than the preceding one.

Counting downward from the 2d Cervical will give its exact location.

3. *Normal position and articulations.*

Its normal position would be when the centrum was true with its transverse and perpendicular median lines.



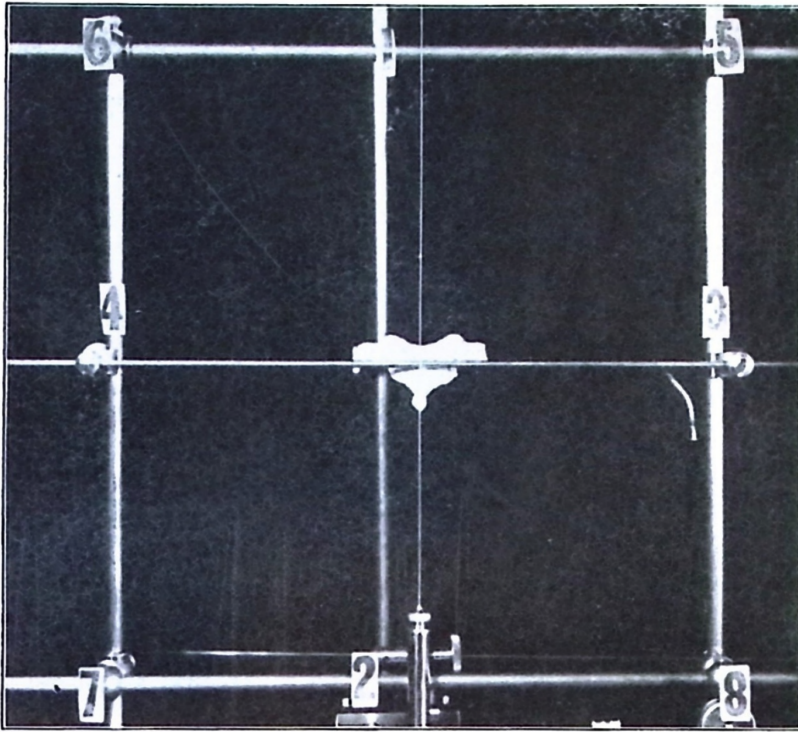


Fig. 207

The centrum is here referred to in preference to the spinous process owing to the frequency of direct blows upon this region in youth, which makes greenstick fractures of quite frequent occurrence. This is a point which a Chiropractor can avoid by closely examining the spinous process in connection with its transverse processes. Its articular surfaces and articulations are in common with general characteristics of the Dorsal vertebrae.

#### 4. *Subluxations, described and illustrated.*

In subluxations of this vertebra we shall lay the fundamental for that which shall be frequently referred to more in the Dorsal region than in Cervical. In the superior vertebrae we deal more with lateral subluxations but in Dorsal we shall have to frequently make use of superior and inferior conditions. The practitioner cannot be too careful to refer to eight direct points which can be compared to the mariners' compass. He has four directions: North, South, East and West, and this is again sub-divid-

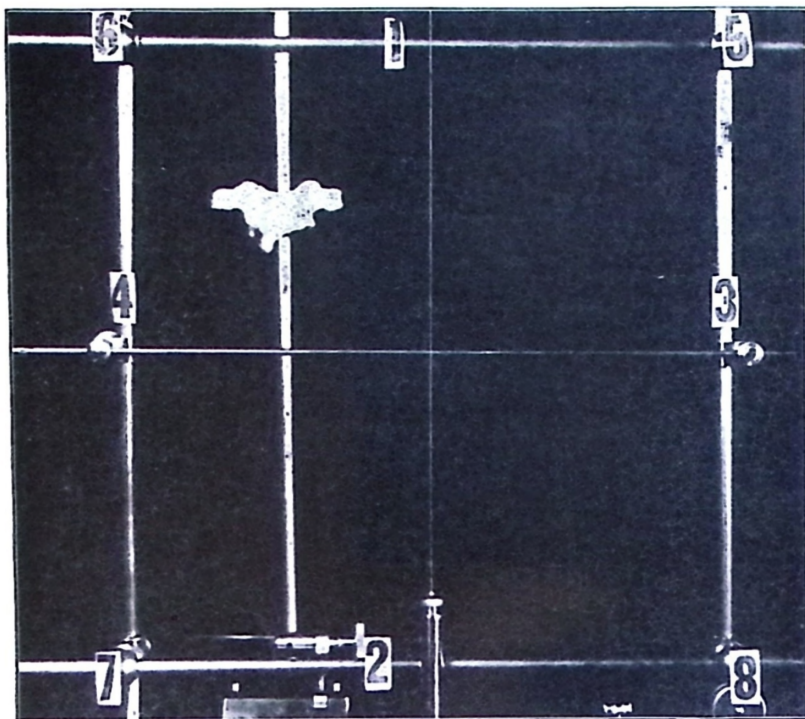


Fig. 208

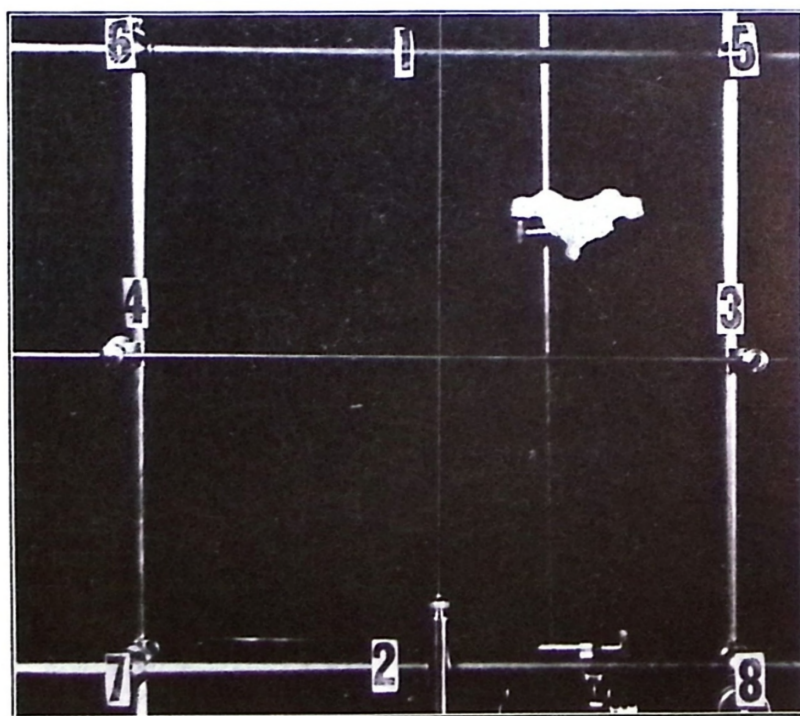


Fig. 209



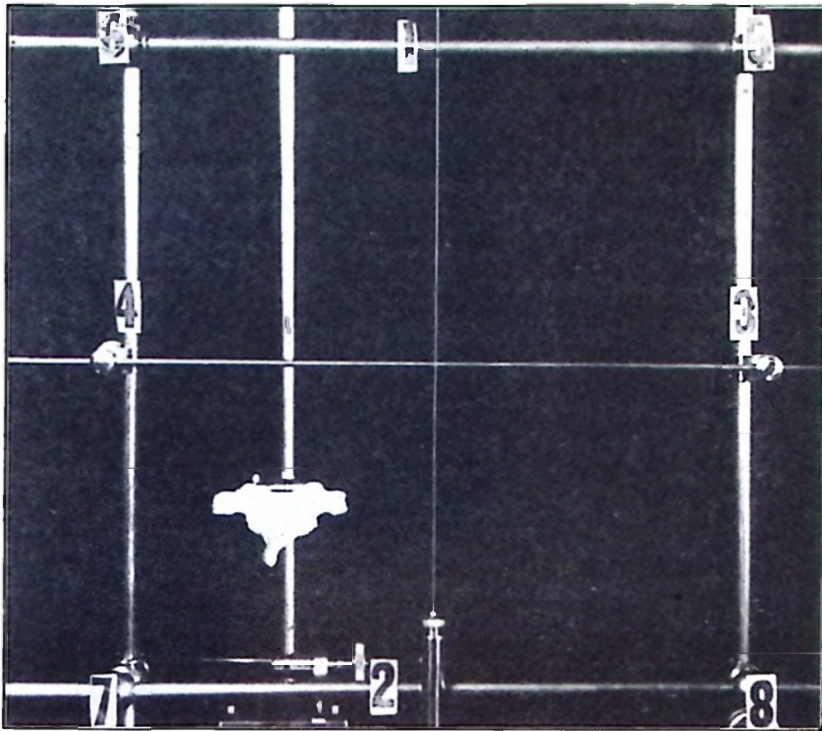


Fig. 210

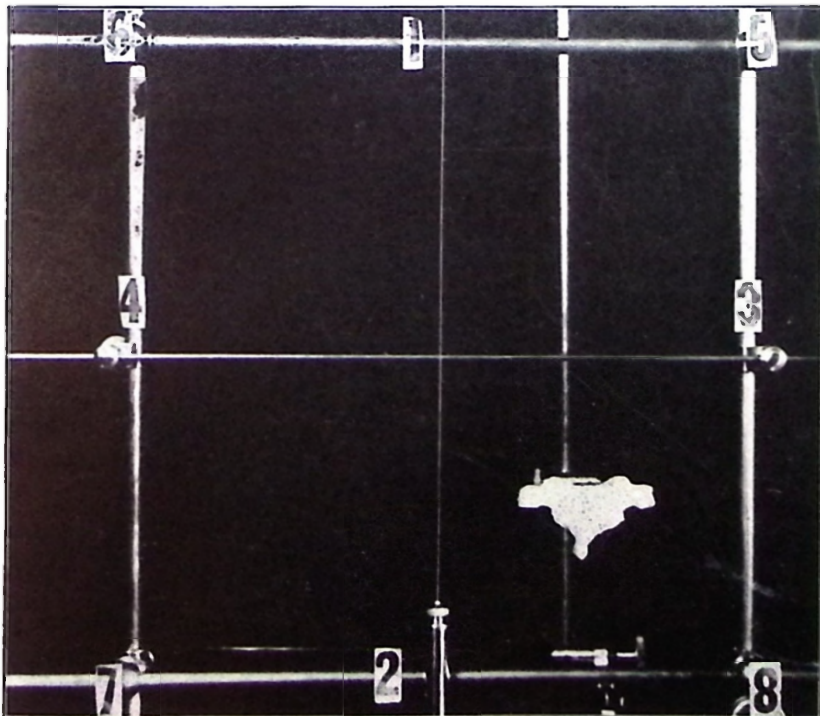


Fig. 211



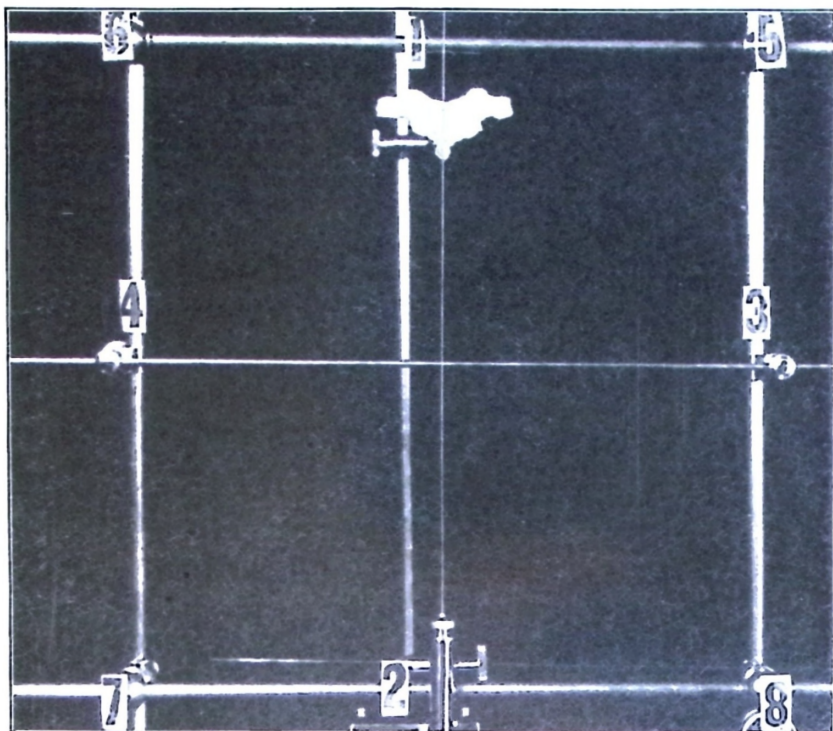


Fig. 212

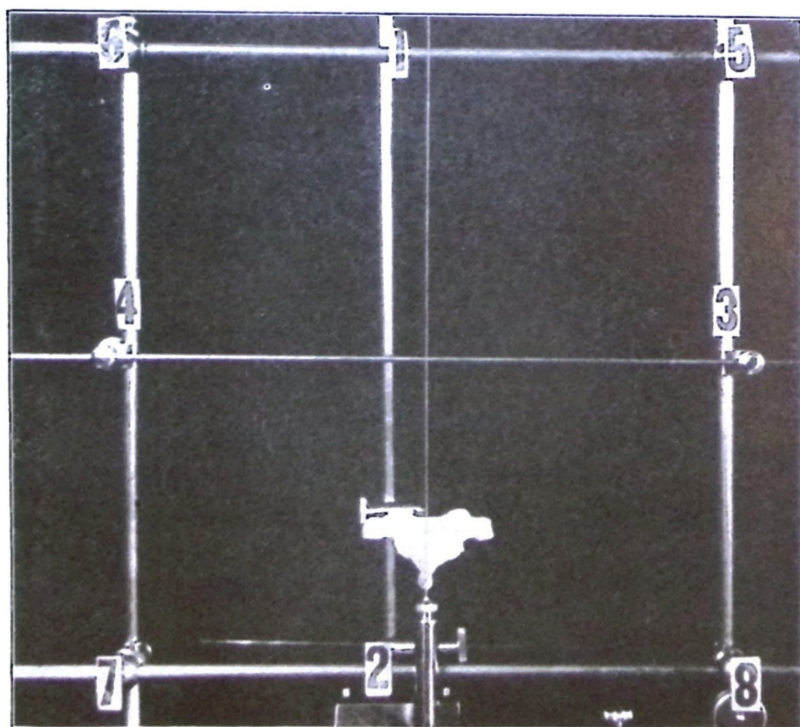


Fig. 213

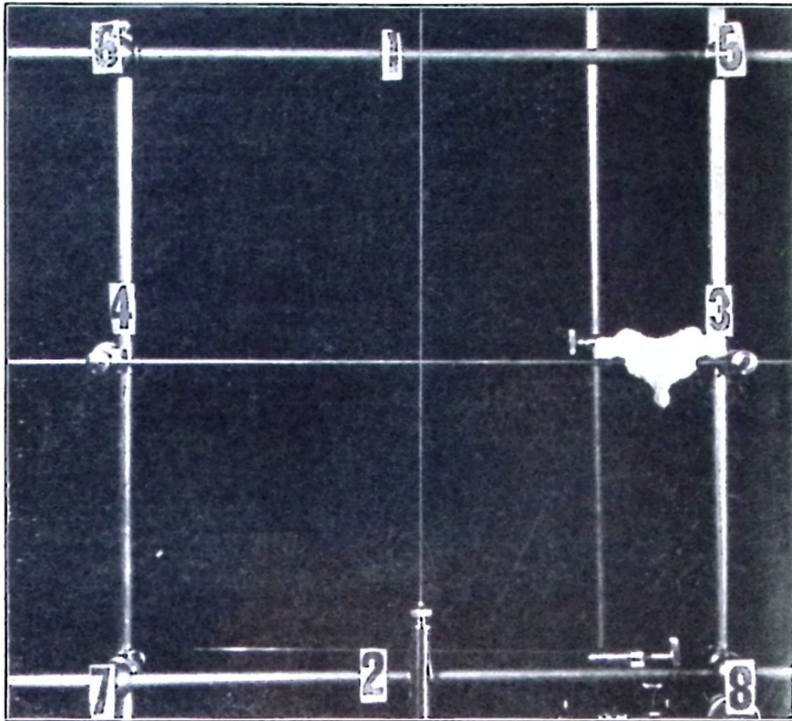


Fig. 214

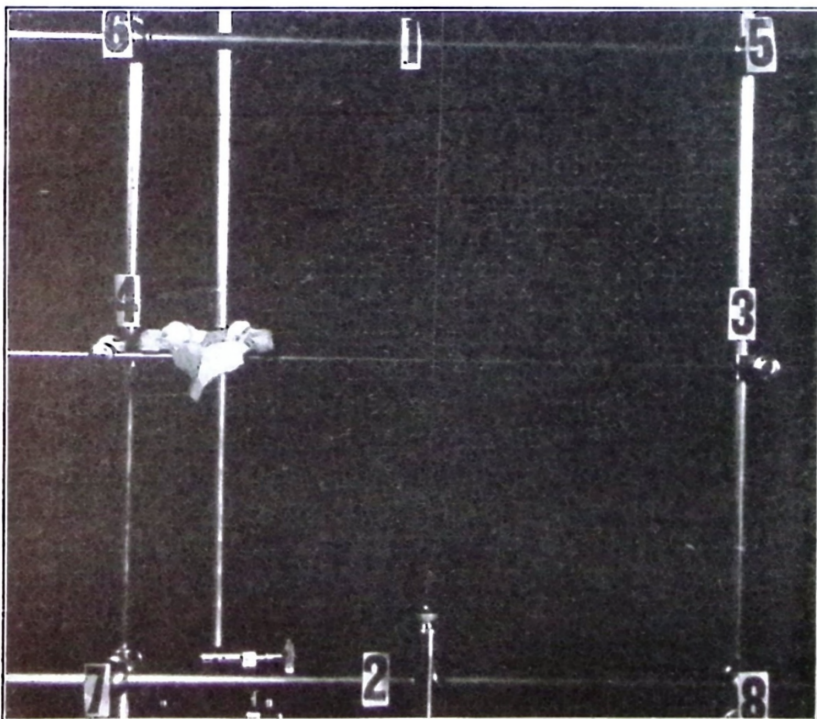


Fig. 215

ed by 4 further conditions, viz.:—Northwest, Northeast, Southwest, Southeast. What is North to him is relatively, superior to us, when the patient lies prone with his head to the North. South is inferior, East is right, West is left. Northwest is superior *and* left. Northeast is superior *and* right. Southwest is inferior *and* left. Southeast is inferior *and* right.

This form of illustrating is unique but conveys the simplified fundamental ideas that sailing a ship on the human body thru life depends upon. It assists the student in studying six simple terms which might otherwise be dwelt upon in an endless jargon of words. In connection with the Dorsal, we wish to portray one prominent feature which is common to all vertebra but more noticeable in the Dorsal and Lumbar, viz.:—the posterior subluxation. With the spinal column in hand and with a keen observation and knowledge of articulations, the reader will soon learn that to produce a posterior subluxation above and likewise below a given center vertebra makes it appear as though an anterior subluxation of the middle one did exist. The Osteopath makes much over the “anterior lesion” but in cases so pronounced you will always find a posterior subluxation existing above or below or both, and it is from these elevations that the Chiropractor takes his basis and makes his deductions not necessarily referring to the general contour outside of the vertebra involved. The posterior subluxation is the landmark of the Chiropractor. It is the high spots or technically speaking, posterior subluxations, that he first looks for and from this determines its abnormal position, the nerves in relation thereto, the zone involved and the consequent diseases that follow a check in the continuous flow of Innate’s life forces. Years of observation have always proven a posterior subluxation to be the basis from which to begin your deductions of any case in hand. These are found singly or collectively, one or more to the extent of all conceivable kinds of curvatures. In substantiation of the posterior subluxation principle, we must know that anterior motions of the spine are very limited but the posterior is only limited by the amount of subluxations, posteriorly that may restrict them. The posterior bending of the column is very great. All dislocations, luxations,



and subluxations occur in a form *to enlarge its normal movements* and very rarely in the opposite direction.

Thus the motion of the spinal column is posterior, subluxations occurring likewise. The quantity of posterior and anterior curvatures are so at variance that there is no comparison. The anterior in general make up is only possible when Pott's disease, caries, necrosis or osteomalacia makes it possible although posterior curvatures are daily met with, without the above pathological abnormalities.

The combination of abnormal posterior conditions are without number and it behooves the student to make 1st, a general survey of the spinal column and then to closely observe *each* sub-luxation so as to determine its abnormal position and how to antipodally correct it. It is impossible to describe one adjustment for all subluxations. Each needs an adjustment unto itself. It is true the entire column is based upon specific mechanical movements. Any one or combination of many may be abnormal at various places in the spinal column.

Your adjustments must vary according to condition and locality, although every movement you may wish to use is based around the preceding illustrations.

For example one movement may be greatly subluxated in superior dorsal and an entirely different kind of a movement be abnormal in the inferior region.

Each student must base his actions upon *what kind* of a subluxation he has to adjust. In palpating the posterior processes one can approximately determine the length of time it has been subluxated. A square tip indicates recent displacement. If the distal end is rounded it indicates the chronic stage.

The length of time is determined by the rotundity of this process. The new hand would be easily deceived by the absent epiphysis of the neurapophysis. This is often fractured in youth and would tend to make the D. O.'s anterior subluxation and to the Chiropractor would make the superior or inferior process look posterior. The general contour, proximal region and knowledge of transverse process, by comparisons will prevent miscarriages of your adjustments.

Fig. 207—Vertebra is in normal position. No adjustment necessary.

Fig. 208.—Northwest, or left superior subluxation. Adjustment would be to Southeast or right inferior.

Fig. 209—Northeast, or right superior subluxation. Adjustment would be to Southwest or left inferior.

Fig. 210.—Southwest or left inferior subluxation. Adjustment would be to Northeast or right superior.

Fig. 211—Southeast or right inferior subluxation. Adjustment would be to Northwest.

Fig. 212—North or superior subluxation. Adjustment would be to South or inferior.

Fig. 213—South or inferior subluxation. Adjustment would be to North or superior.

Fig. 214—East or right subluxation. Adjustment would be to West or left.

Fig. 215—West or left subluxation. Adjustment would be to East or right.

##### 5. *Relative position of adjacent vertebrae.*

According to the above, the greatest variations would be in antero-posterior positions. Heretofore the consideration has been more for the lateral and superior or inferior conditions. In addition to these we have the above. This is as important to the Chiropractor's work, as the compressing of vertebra together, for it is the change in antero-posterior position that materially changes the size and shape of the intervertebral foramina. The importance of this significant point must not and cannot be overestimated. That is why the posterior subluxation is so important to the Chiropractor.

##### 6. *Where nerves are impinged.*

From the foregoing paragraph we can readily realize how and where nerves can be impinged. The different combinations of variously distributed effects would be entirely due to the many and peculiar shapes into which this

movable opening could be twisted, thus creating pressures upon the various nerves conveying the many different functions.

7. *How and what makes pressures.*

This has been detailed under Part 5 and 6.

8. *Functions and organs involved. Location of—*

The first Dorsal nerves have no vital distribution other than it emits those fibres which spread over a region that may be bounded as follows: both arms in any or all functions both superficial and deep; shoulder regions as low as center of scapula superficially; upper portion of bronchii are reached by adjustments here, but outside of that we may say with rare exceptions it only controls the external of subcutaneous tissues as outlined above.

9. *Adjustments necessary to correct each.*

10. *How to give adjustments correctly.*

Close attention should be given in all adjustments to the position of the body. We have described in the hammer and nail comparison the exact positions of the hands in order to get the greatest force with most elasticity, as is necessary to secure best results.



Fig. 216



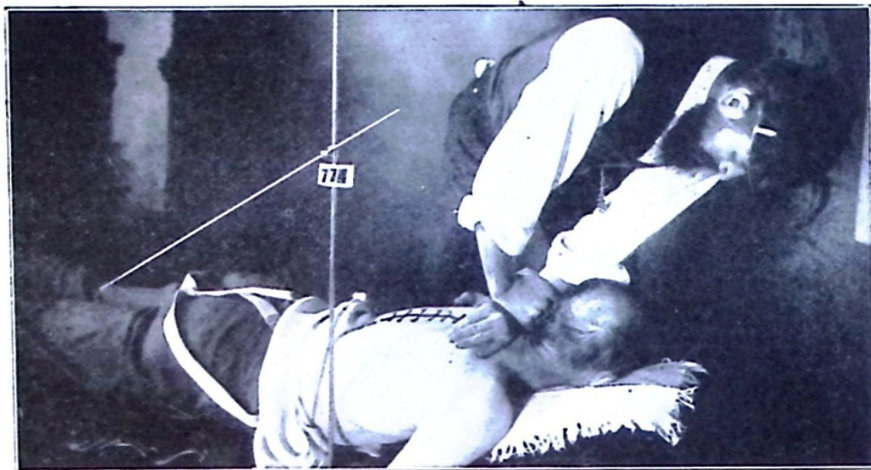


Fig. 217



Fig. 218

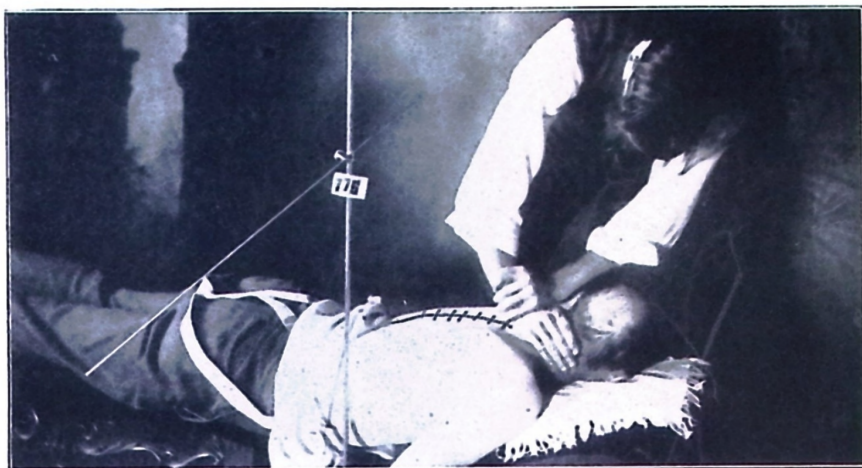


Fig. 219



Fig. 220

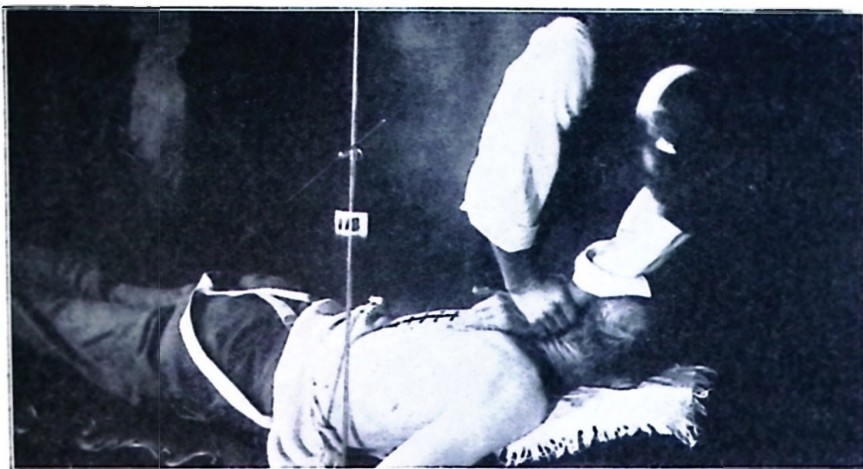


Fig. 221



Fig. 222



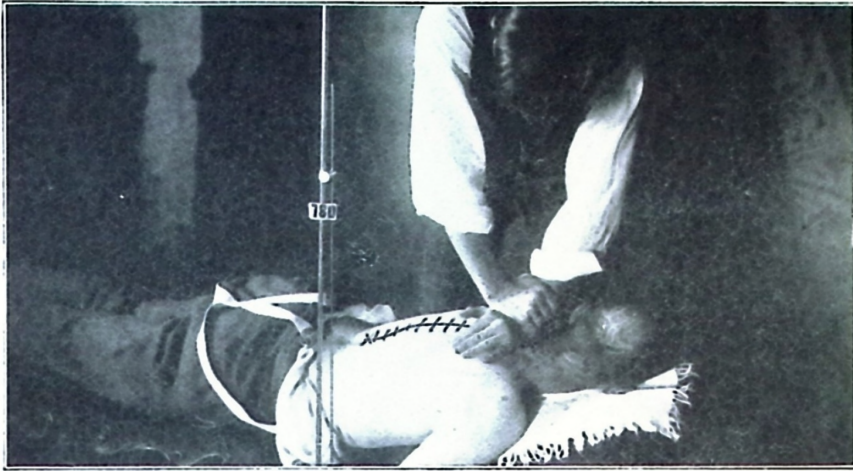


Fig. 223



Fig. 224



Fig. 225

The arms should direct the position, viz:—The slant from or towards the median lines should indicate the direction in which the adjustment is given.

With the shoulders at a fixed point and elbows slightly bent the quick movement that is made by drawing the elbows together with a simultaneous drop of the shoulders is just such as will be sufficient to adjust the ordinary subluxation. The shoulders and upper portion should be as a fixed point directly over the arms. If the adjustment be given inferiorly the shoulders and arms would be on a slant obliquely up and forward. A plumb line from the center between shoulders, or anterior, would be removed from the locations of hands according to the degree of desired adjustment.

If the adjustment be one of direct anterior then the shoulders are directly above the location of hands and plumb line ought to touch the same.

The same is true of a lateral adjustment. The shoulders and a plumb line therefrom would be to lateral side of the vertebra being adjusted.

The body in all cases should be swung in the opposite direction to that in which the vertebra is desired to be placed, thus concentrating all force to a focalized point, getting greatest weight and power together for one direct, specific and quick movement. The position of the body

has much to do with the success and ease in adjusting all kinds of vertebral subluxations. On the facility which you express in this work depends much upon your adaptation with your body, arms and hands, to the abnormal position of the subluxation. Never allow the patient to lay on thon's arms when prone on the table. Watch this as serious injury might otherwise be inflicted.

Fig. 216. *Right* subluxation, first dorsal. Adjustment is to *left*.

Fig. 217. *Superior* subluxation, first dorsal. Adjustment is *inferior*.

Fig. 218. *Inferior* subluxation of first dorsal. Adjustment is *superior*.

Fig. 219. *Left superior* subluxation of first dorsal. Adjustment is *right inferior*.

Fig. 220. *Left inferior* subluxation of first dorsal. Adjustment is *right superior*.

Fig. 221. *Right superior* subluxation of first dorsal. Adjustment is *left inferior*.

Fig. 222. *Right inferior* subluxation of first dorsal. Adjustment is *left superior*.

Fig. 223. *Posterior* subluxation of first dorsal. Adjustment is *anterior*.

Fig. 224. *Posterior superior* subluxation of first dorsal. Adjustment is *anterior inferior*.

Fig. 225. *Posterior inferior* subluxation of first dorsal. Adjustment is *anterior superior*.

11. *What means and portions thereof, to use.*

The same members and portions thereof that have been described heretofore are applicable here.

12. *What diseases to adjust the first dorsal for.*

The diseases that might be expressed, due to a subluxation of this vertebra and its consequent pressures upon nerves, superior or inferior may include any or many *endless* combinations of functions enumerated in the location of No. 8 on this vertebra. This is concerned in heart troubles on left due to pressures upon nerves in left inferior foramina. This is rare but does occur. This fact



has led to this vertebra being sometimes called U. H. P. In Bronchial troubles this is a prominent factor and in Chronic Asthma, we have the peculiar "Asthmatic Curve", i. e. a local kyphosis of 3 or 4 vertebrae.

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Fig. 207. Square showing 1, 2, 3, 4, 5, 6, 7 and 8 with first dorsal exactly in center. This illustration carries out the compass idea to the Chiropractor. 1, is North; 2, South; 3, East; 4, West. 5 is North East; 6, North West; 7, South West; 8, South East.

Fig. 208. 1st dorsal. *North West.*

Fig. 208. 1st dorsal. *North West.*

Fig. 209. *North East.*

Fig. 210. *South West.*

Fig. 211. *South East.*

Fig. 212. *North.*

Fig. 213. *South.*

Fig. 214. *East.*

Fig. 215. *West.*

## CHAPTER 13.

## 2. DORSAL.

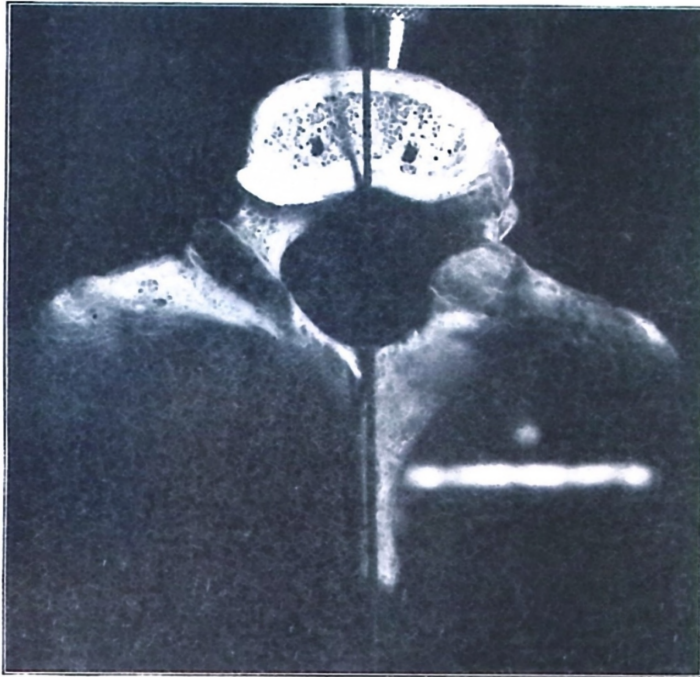


Fig. 226

1. *Vertebra and its title. U. H. P. or L. H. P.*

The bodies of all movable vertebrae are united by the interposition of the disks of intervertebral fibro-cartilage, of which there are twenty-three forming about five and a half inches, of the length of the vertebral column in a person of average stature. Each disk consists of outer concentric layers of fibro-cartilage surrounding a pulpy nucleus which resembles a synovial sac.

This is approximately in the center of the fibro-cartilage, and contains a small irregular shaped cavity. The superficial layers cross one another taking an oblique direction from side to side. The smallest of these disks are between the fifth and sixth cervical, from which they gradually increase downward. In the cervical and lumbar regions they are all higher behind than in front. The second is peculiar in that the pedicles occupy a higher

plane than the upper surface of the body when the vertebrae are in position.

2. *Superficial palpation and land marks.*

Superficial palpation at this point is usually easy, especially if there be a well marked subluxation. The shoulder region has a limited motion therefore flexing the body would give little aid in determining the condition of abnormality. Bending forward usually compresses the centra and spreads the spinous processes and palpation under these circumstances, at any place in the spine, is examining it under strained conditions. In other words you are determining abnormalities that you have caused to be made greater. This is a good means of exaggerating the conditions and proves them up easier but I cannot recommend it as being accurate in assisting palpation for subluxations.

Palpation should be conducted with accurateness when the patient is in what *is to him* a restful or easy posture. Palpation while on the divided bench is the opposite or exaggerated in the reverse conditions and is not exact and the student must remember how the vertebrae were while in the sitting or prone position on a *flat* table.

3. *Normal position and articulations.*

The articular surfaces of the centra and articulations

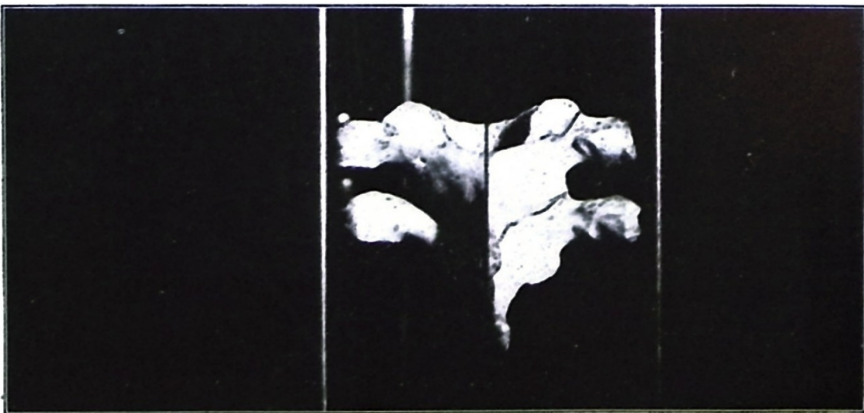


Fig. 227



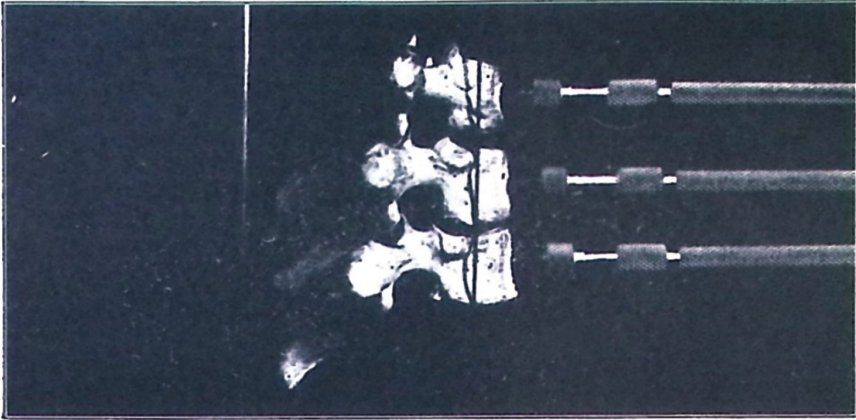


Fig. 228

of all processes are alike in all Dorsal vertebrae, the difference existing in the number and position of costal articulations.

4. *Subluxations, described and illustrated.*

The mobility of the Dorsal vertebrae becomes greater as we approach the 12th Dorsal although proportionately, it is supposed that the size, solidity and strength of the ribs correspond to the increased liability caused by greater motion. Experience as a Chiropractor does not bear out this fact but, on the contrary, we find that all Dorsal vertebrae are particularly adaptable to subluxations. Outside of this general Dorsal observation, the subluxations are similar to those of the 1st Dorsal, remembering that its range of movement is greater, therefore the degree of subluxation corresponds, and as a general thing the degree of pressure is equivalent to amount of subluxation.

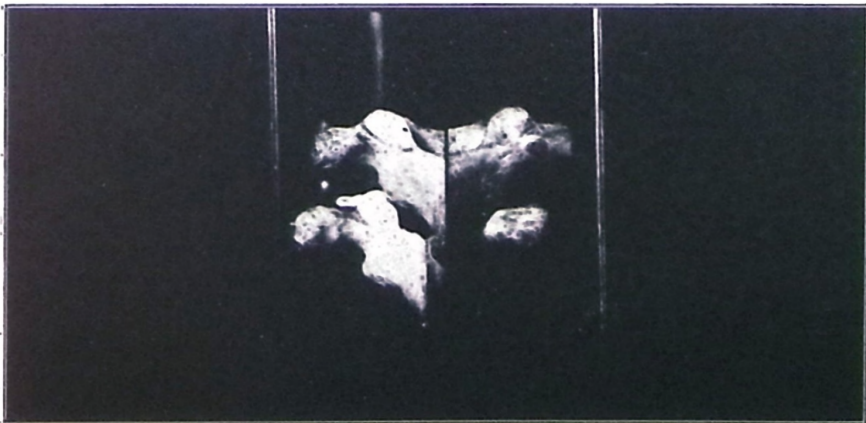


Fig. 229

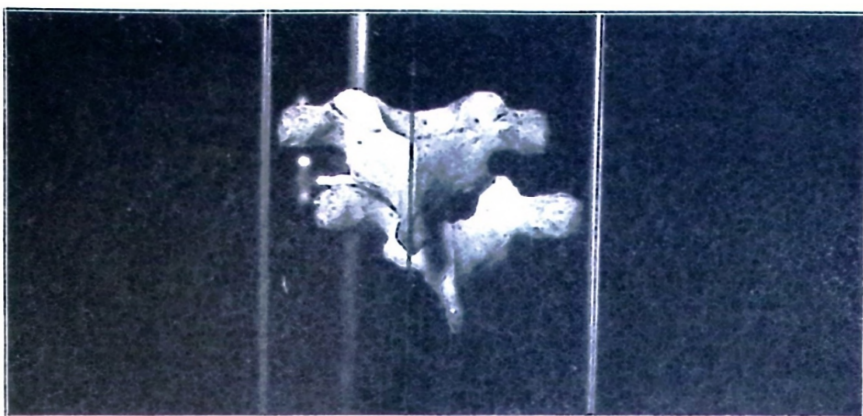


Fig. 230.

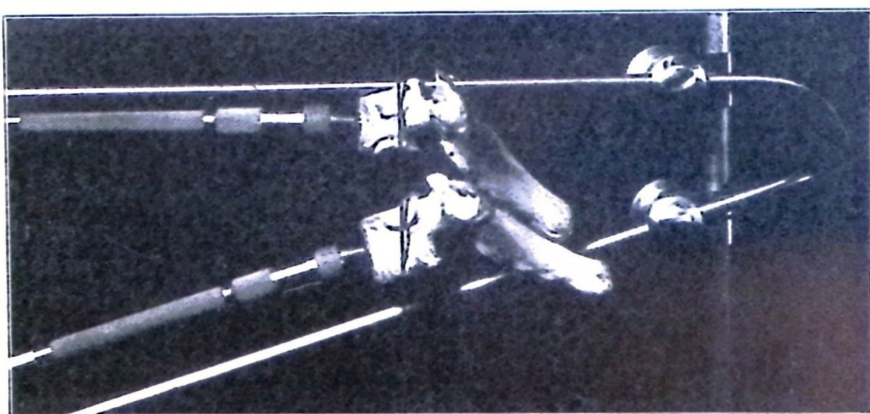


Fig. 231

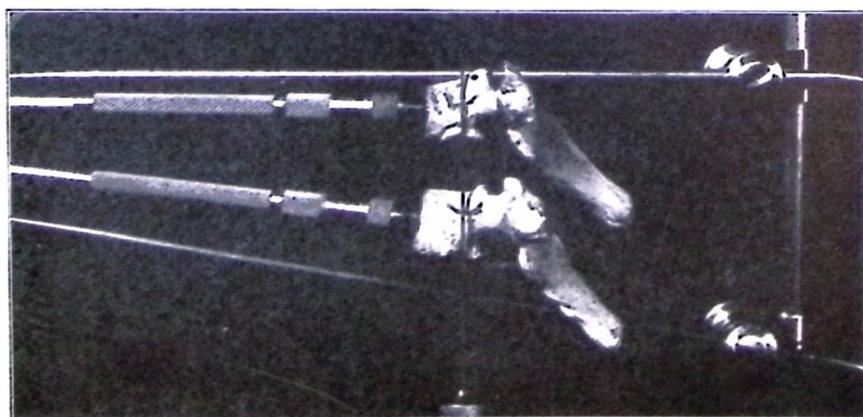


Fig. 232





Fig. 233

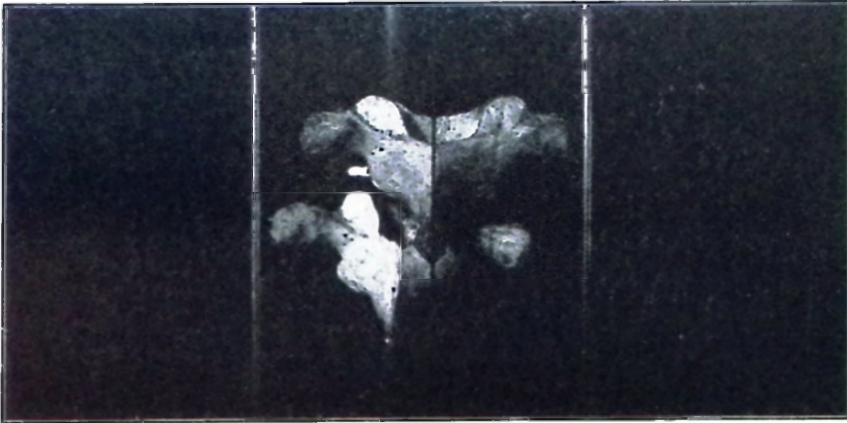


Fig. 234

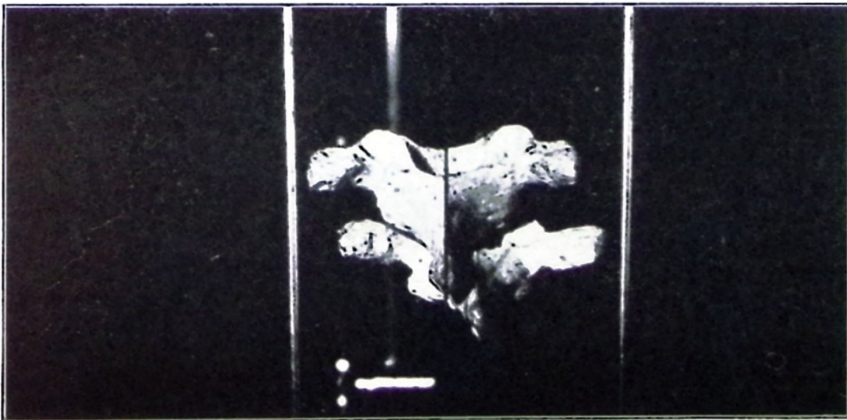


Fig. 235



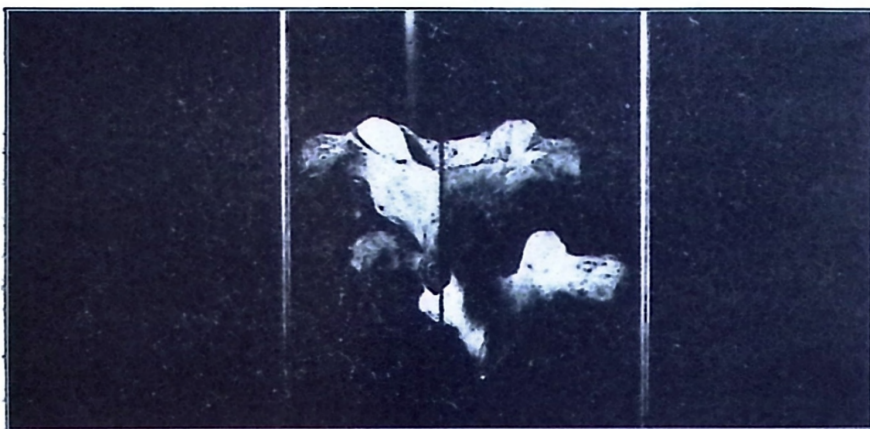


Fig. 236

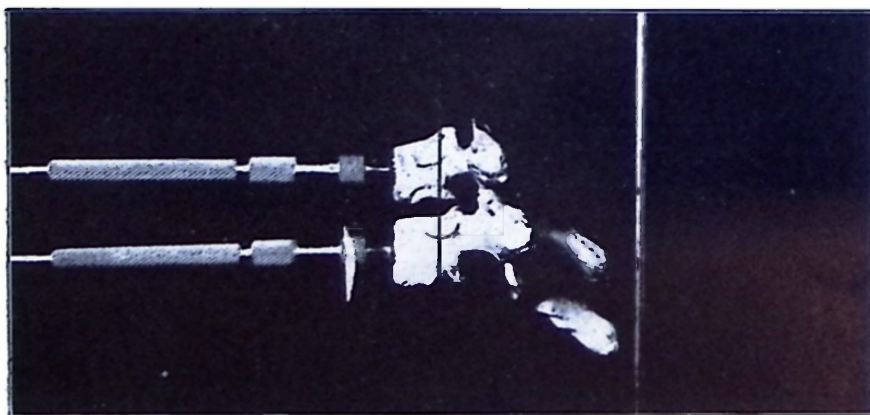


Fig. 237

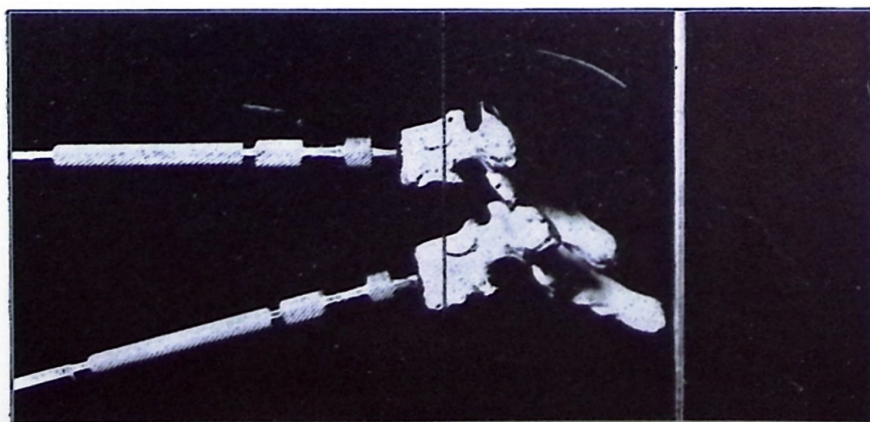


Fig. 238

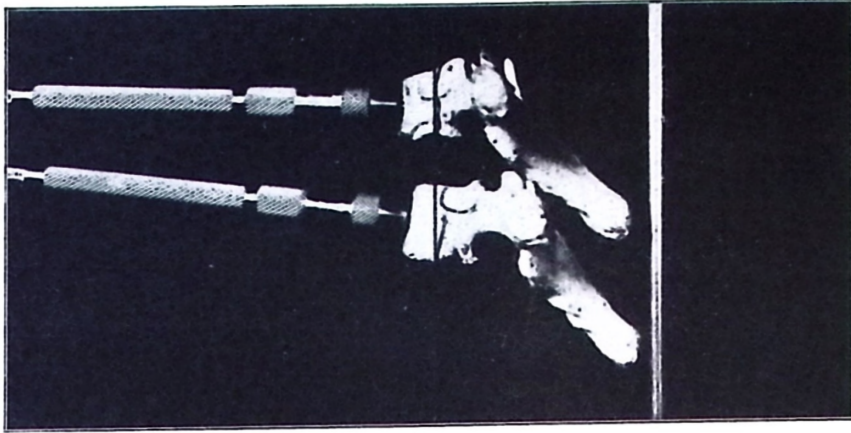


Fig. 239

Fig. 227. *Posterior view of first and second dorsal vertebrae. Normal.*

Fig. 228. *Right lateral view of first, second and third dorsal to show relative depressions of spinous processes.*

Fig. 229. *Left subluxation of second dorsal. Posterior view.*

Fig. 230. *Right subluxation of second dorsal. Posterior view.*

Fig. 231. *Superior subluxation of second dorsal. Lateral view.*

Fig. 232. *Inferior subluxation of second dorsal. Lateral view.*

Fig. 233. *Left superior subluxation of second dorsal. Posterior view.*

Fig. 234. *Left inferior subluxation of second dorsal. Posterior view.*

Fig. 235. *Right superior subluxation of second dorsal. Posterior view.*

Fig. 236. *Right inferior subluxation of second dorsal. Posterior view.*

Fig. 237. *Posterior subluxation of second dorsal. Left lateral view.*

Fig. 238. *Posterior superior* subluxation of second dorsal. Left lateral view.

Fig. 239. *Posterior inferior* subluxation of second dorsal. Left lateral view.

### 5. *Relative position of adjacent vertebrae.*

The 1st Dorsal is almost a fixed point therefore the larger percent of supposed subluxations of the 7th Cervical would be with the 1st and 2d Dorsal below. Correspondingly the 3d would be greater than 2d.

### 6. *Where nerves are impinged.*

The size of the nerves and blood vessels is sufficient to almost fill the intervertebral foramina, therefore we shall consider what is a normal amount of free play at such junctions. It is when the abnormal extent of movements, combined with external shocks, are brought to bear upon such articulations that they are more or less torn from their usual movement, hence we have a *partial* dislocation or luxation termed subluxation. It is in this excessive condition that the openings are made smaller and pressure exists upon nerves. Arteries and veins are equally as much compressed but the former have very ample anastomoses representing a provisional nature of adaptation. As for nerves they are fibres with a point of origin and one of insertion expressing a transmission is *one* direction, hence pressure upon that interferes with the life current which does not know anastomoses until expressed, then functions are harmonious and in unison with many like motions.

Arteries and veins that pass in and out have their normal anastomoses therefore it is impossible to obstruct such a flow for one moment. Nerves are composed of fibres which have direct starting points,—brain—and—specific peripheral tissues in which they end. They have no intervening or connecting substances with which they can communicate; in other words have no inosculation; therefore interference with their direct transmitting or conveying powers by pressure of a hard substance, bone or by an occlusion of this opening, would mean stoppage or a lack of the Innate force current that nerves convey, hence disease.



7. *How and what makes pressure.*

This has been described and detailed most carefully under point No. 6.

8. *Functions and organs involved. Location of—*

The functions involved would be common to all tissues and are necessary to the equilibrium of the mental with physical. The location takes in the region of the arms, shoulders, upper bronchii, chest, heart, upon left and sometimes upper division of lungs and pleural sac.

9. *Adjustments necessary to correct each.*

The foundation as laid down under 1st Dorsal vertebra is applicable to all vertebrae. I cannot conceive of a single movement possible to give vertebrae, regardless of location, degree of subluxation or condition but, what must be adjusted under some one or combination of several of those outlined. The accuracy depends upon the correctness of the analysis given previously and for this reason, I prefer the comfortable sitting posture for detailed exact positions of the subluxations.

10. *How to give adjustments correctly.*

In giving Chiropractic adjustments there are many points to be involved. While it is true that anyone can push bones into place and make them "pop" or "crack", that is far from delivering an accurate and exact correction of subluxations, and getting the attendant results.

I know of no more accurate or precise work than this and it is only close application, utilization of all points at one time that makes the student a capable man at his bench. To use one well and fail utterly upon another is oftentimes sufficient to spoil what good might otherwise have been certain. Many pseudos are getting results but it is by using a haphazard method. They do not know the basis upon which it was accomplished and tomorrow might and possibly would, in the majority of cases, fail. The thoroughly posted ought to be able to decipher why they could not get results, and this culmination can only be attained by a most complete philosophical

and practical knowledge of the principles which underlie his work. If the patient but gives the thoroly posted Chiropractor the proper time, failure will be a stranger that knocks but seldom at his door.

The following article involves the idea of "recoil." For fear that the lay mind will not accept this word as it is intended, *its broadest sense*, I quote from two dictionaries to show how it is used.

"Recoil. *To start, rush, roll or fall back, as in consequence of resistance which cannot be overcome by the force impressed,—to fall back after an advance.—To be driven back or forced to retreat,—to fall back. To start or shrink back, as from something repulsive, distressing or alarming. To shrink through fear,—to go back; to revert,—to drive back. "New Revised Encyclopaedic Dictionary.*

"Recoil. *To start, roll, bound, spring or fall back,—to be driven or forced backward,—to draw back, as from anything repugnant, distressing, alarming, or the like, to shrink,—to draw or go back."* Webster.

"Why and what is the object of a quick, light, energetic, piano touch, adjustment in preference to a slow push, shove or thrust upon the verterbrae?" is a question students frequently ask. *All forces, whether normal or abnormal, have a certain degree of recoil, resisting force*, that is utilized for good or bad according to its degree. A fall occurs: the concussion of forces creates an excessively abnormal rebound which does not allow the vertebra to recoil to its normal position hence it becomes an anomolous specimen, exhibiting subluxations not alone in position, but conveying to the Chiropractor the knowledge of damage to the current flow that passes between its openings. The violence of the forces that were spent at the time of the fall, wrench, strain, or other injury, was too much for the normal contractions to handle, hence became a reverberating recoil that no longer could be controlled by Innate—a resilient monster. This means that it cannot resume its normal position, after the shock has been spent, for it has settled in the position determined by terminal cessation of vibrations.

*The Chiropractor judiciously reverses this initial order... He uses force with the added knowledge of how to reverse its direction from what it was to what it must be. A moderated concussion of forces is daily brought into play. Instead of throwing terrific power into his work, he, in a mild manner, utilizes, with keen discrimination the ability to draw back or return with concussions, the temporary object of which is to create a toned down, successive series of recoils, having for their permanent intention the steady returning to a normal flow of Innate Impulses. His concussions created voluntarily, are in a definite direction with the object of gradually working the vertebra back to its original articulations. By so doing, the obstruction made by the former subluxation is gradually opened. His work creates a beginning and allows Innate to enlarge foramina by recoils and finally does more than that—viz: re-establishes the current between Innate and her physical body.*

Subluxations are caused by concussion of forces, *excessively and awkwardly applied*. The interruptions to the normal flow of Innate mental impulses is the *cause of all diseases*. When conditions are made possible, a gap created, Innate can, will and does reverse the order and uses the same means, but in a different direction and degree. The manner of the former (fall, wrench, etc.) was such that it was put out of place; of the latter (Chiropractic adjustment) to correct it. The former external forces were too great for Innate to master or circumvent. In the latter case it is within her grasp and therefore is utilized with that degree of intelligence by which that personality is characterized.

To accomplish this, the student must keep constantly before his mind, *not how much to punch, thrust, drive, pull or compel verterbrae to go into place, but how to give the movement* so as to create an internal, responsive action—Innate recoil—which replaces it in juxtaposition. *The recoil should be his sole aim*, and the more intelligently he can work with that end in view, the better are his results.

Falls, wrenches etc., are attended with stuns, dazed conditions, and shocks. This is the abnormal recoil fol-



lowing the abnormal application of an excessive concussion of forces, consequently and subsequently followed by occlusion of foramina, pressure upon nerves and interruption of mental currents, hence disease. The fall will do in one moment, on account of its terrific velocity, what the Chiropractor will work to accomplish in days, weeks, or months, but the latter will take it step by step, day after day. It is not within his province to undo *all at once* what took place by such harsh, irrational means, not but that it could be, and is being done by inexperienced hands, but too often the risk proves fatal to life.

The object is not alone to hear bones click, or to aim in getting a "movement" between vertebrae, for often vertebrae move every day *and yet no benefits are derived*. Why? Because vertebrae are not returned to normal articulations for this cannot occur unless a recoil exists, brought about by an intelligent administration of external force so that Innate can adapt it to an assumption of a new or the old normal position. The results of concussion of forces must be studied in each case and correction by a reversal of the former must be applied in an evolutionary manner. Make every move tell by that quick, energetic, light, metallic touch that makes the Chiropractor's adjustment different from anything that has preceded him.

The attempts at corrections of deformities, by any means whatsoever, have always been a slow and tedious process. The object was to see *how slowly and steadily* the *effects* could be forced into normal line. The cause of all abnormal functions is an instantaneous concussion of the external force coming in contact with the resistance of the internal, followed by a rebound which cannot assume the normal on account of its violence, costing the patient the loss of a flow of life elements. The corrections must be equivalent, although heretofore they have been along antipodal lines. Instead of applying tit for tat at the residence of the cause, it has been a tug and pull proposition upon effects.

The principle taught in setting fractures and dislocations is the nearest approach. The endeavors were to produce relaxation by natural or artificial means and then, with a steady pull *and* a moderately quick movement, reset

the fragments by a rebound opposite to its present abnormal position. What forces were used? The reversal of the ones that caused it. The same ideas with the addition of the laws of causative factors are elaborated upon and made into a philosophy, science and art in Chiropractic adjustments where levers (spinous processes) are used in adjusting subluxated vertebrae to reinstate the fulcrum (articular processes) to again restore Innate Intelligence to her dwelling place.

Chiropractors make an external agitation but Innate creates the recoil and then the simultaneous action corrects the cause. We, by using our hands, against vertebral processes, in a quick, energetic manner, create a demand for resistance which is met by an internal intellectual response; it is this answer to our call that exactly shifts or transfers the vertebra into normal position.

While we arrogantly claim the honor of the simple and exact results that follow, we are but the instruments that guide the external impetus. We do not create or generate the power that *we* used nor the responsive force from the patient, hence we are but an instigator for the concussions of force which would be useless were it not for Innate Intelligence. The continued application of this external work is a counterpart to the internal Innate that persistently replaces the vertebra until it has returned to normal. It is the power that Innate has utilized in these local spots that expresses her ability to replace the vertebra. Innate creates power, causes its expression, resistance, the function of which is to replace vertebrae, and then generates sufficient intellectual, inherent power, to run the organism along normal planes so long as external violences do not again occur.

A good proof of the above is that persons receiving violent concussions of forces will often hear or feel the vertebra move to an abnormal position several or many seconds after the fall, while the shock is yet spending its power. I have, many a time, heard the vertebra return to normal several seconds after my hands have been taken from the body. *Immediately* after the adjustment, the hands are withdrawn and it is then that the vertebra is heard (upon the part of the adjuster and felt by the

patient) to return to its normal position. Especially is this noticeable in acute subluxations.

11. *What means, and portions thereof, to use.*

In conclusion of the above we must use the shoulder movement and position, arms must be directed correctly, hands in the proper positions and all must aid in giving the right movement in a simultaneous manner. The adjustment then will have been correctly given. Concentration of detail until focalized, is the hardest labor the student meets in his work. The willingness to do and remembering all points and then the execution at one time is what makes one a better success than others.

12. *What diseases to adjust the second dorsal for.*

The many and various diseases of the heart, such as palpation, etc., rheumatic conditions of shoulders, arms, chest and upper back region.

Contractures of aforesaid regions, Asthmatic or hay fever troubles predominate prominently at this point. The superior portion of pleural sac might be involved in such abnormalities as pleurisy, pneumonia and neuralgic pains upon breathing etc.



## CHAPTER 14.

## 3D DORSAL.

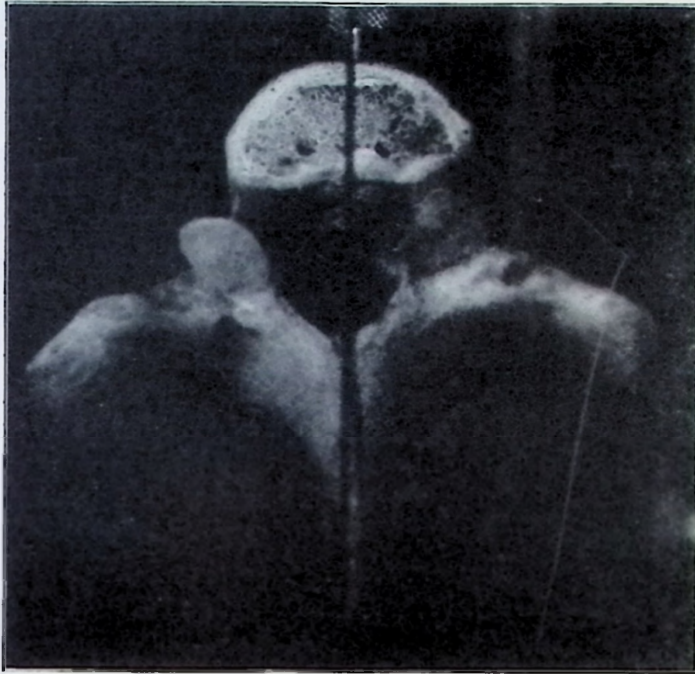


Fig. 240.

1. *Vertebra and its title. L. H. P. or U. L. P.*
2. *Superficial palpation and landmarks.*

In palpating for subluxations there is no set rule which can be held firmly in all cases. Where a disease has its correspondent subluxation may vary. In the embryological study, it has been determined that the spinal column expands faster proportionately than the spinal cord and thus the early formation of the foetus is not always positive as regards the exit of nerves upon leaving the vertebral column. What is known as "H. P." in one individual may slightly vary above or below in another, i. e., in one foetus the fibres emit at a position superior to what they would in another thus shifting the location of those nerves that go to the heart. It is thus impossible to say that 3rd Dorsal is *always* Heart Place. Such locations are determined by the general average and palpation of many cases.

For convenience, *The P. S. C.* many years ago, worked out the following survey of the vertebral column. This always can be relied upon but not always the same in two people as the nerves are not always localized in the same place. This is a general plan, more than a specific one, of

the nerves, zones and their distribution and what portions of the spine the nerves emanate from and is, as it were, a majority index. The Chiropractor must take each patient and make it specific.

The branchings of the nerves, in two people, are not the same, therefore the application of this system must be made to each case individually. It is for this reason that *The P. S. C.* refuses to sanction any particular set as a "key" for any one would be wrong in some cases although correct in a particular one after which it has been patterned.

For instance, "H. P." could be localized at one vertebra in person "A" and in "B" it might and could vary by two vertebrae. That is why a latitude of 2 or 3 vertebrae is allowed in the following chart.

The principle is such that it must be examined and individualized to each patient that comes to you.

1st .....Cervical ....At. P. (Atlas Place.)

2d .....Cervical ....Ax. P. (Axis Place.)

3d .....Cervical ....U. C. P. (Upper Cervical Place.)

3—4—5..Cervical ....M. C. P. (Middle Cervical Place.)

5—6.....Cervical ....L. C. P. or U. A. P. (Lower Cervical Place or Upper Arm Place.)

7.....Cervical ....V. P. (Vertebra Prominens.)

1—2 ....Dorsal .. ..A. P. or U. H. P. (Arm Place or Upper Heart Place.)

2—3—4..Dorsal .. ..L. H. P. or Lu. P. (Lower Heart Place or Lung Place.)

4—5 ....Dorsal .. ..Li. P. (Liver Place.)

5—6 ....Dorsal .. ..C. P. (Center Place.)

5—6—7..Dorsal .. ..S. P. (Stomach Place.)

7—8—9..Dorsal .. ..Spl. P. (Spleen Place.)

10-11-12..Dorsal .. ..K. P. (Kidney Place.)

1—2 ....Lumbar ....U. P. P. (Upper Private Place.)

2—3—4..Lumbar ....P. P. or U. R. P. (Private Place or Upper Rectal Place.)

4—5 ....Lumbar ....L. P. P. or R. P. (Lower Private Place or Rectal Place.)

Sacrum ....Sa. P. (Sacrum Place.)

Coccyx ....Cc. P. (Coccyx Place.)

Nerve tracing makes this work exact and precise, de-

termining to a preciseness the foramina from which the impinged fibres have their exit. Chiropractors place the 3 fingers on the region and determine some one of the foramina underneath where the pressure exists and fibres going to the organ that he wished to locate. Each disease had a local zone and in this region is one specific subluxation which is producing direct pressure upon certain fibres interfering with a continuous flow of mental impulses and making a pronounced disease. Pressure may be at peripheral as well as at the exit from the spine. Traumatism may, can and does occasionally create local pressure but unless accompanied with shock sufficient to produce subluxation (which is usually the case) will only make local and *temporary* symptoms. If subluxation follows as a consequence to the traumatic concussion, the disease will be permanent. If a nerve be found tender, it is impinged, the degree of sensation depending upon how much pressure is interfering with functions. Occasionally a case of paralysis (this term is used in its broadest sense to mean wherever there is lack or excess of function) will appeal for help but palpation and nerve tracing reveals no tender nerves. This is due to pressure being so great that no impression can reach the brain to be interpreted. But in such instances, close proximity to the region of the subluxation reveals taut nerves, thus determining the location of the cause.

Combining the analysis with nerve tracing and knowledge of cause makes accurate work for the Chiropractor. Under this head it is well that we speak of the quality of feeling of nerves in various people. The facial appearances, temperaments, physical qualities and dispositions are different. These actions are but the expression of what exists. They are different and this condition of contrast is in the Innate adaptability to external circumstances. One individual may even assist the surgeon in removing an extremity.

It is often referred to as "grit", but is due entirely to the different quality in the feelings and abilities to convey these impressions. Another person would faint at the sight of blood, or the removing of a sliver from the finger. The same conditions exist in the patient telling of his pains



or aches. One will exaggerate and the other mildly state symptoms when most excruciating pain is being endured. This factor must be taken into consideration in palpation and nerve tracing. Due allowance must be made for this susceptibility and manner of statement.



Fig. 241

3. *Normal position and articulations.*

The location of this vertebra, in relation to its mates is similar to those described in the past.



Fig. 242

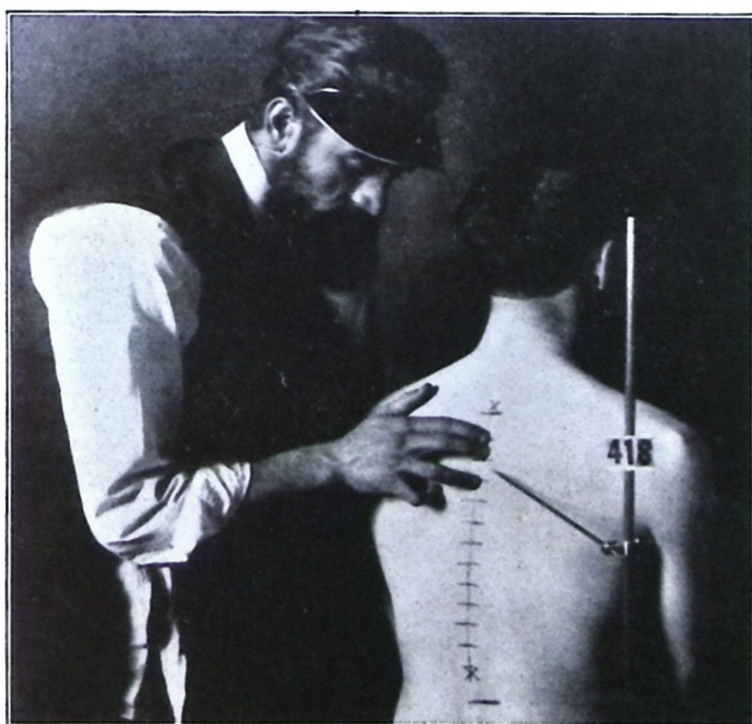


Fig. 243



Fig. 244



Fig. 245





Fig. 246



Fig. 247

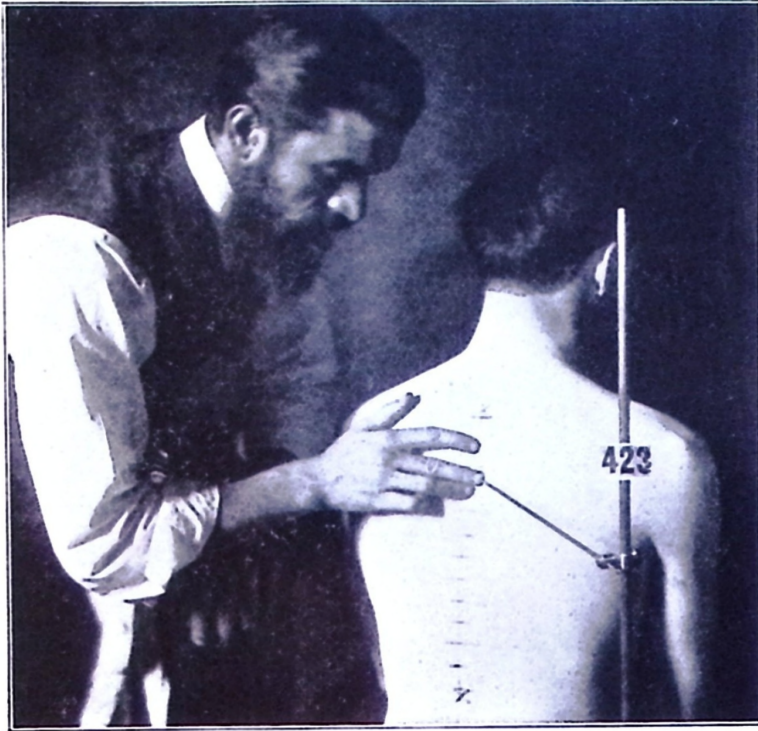


Fig. 248



Fig. 249



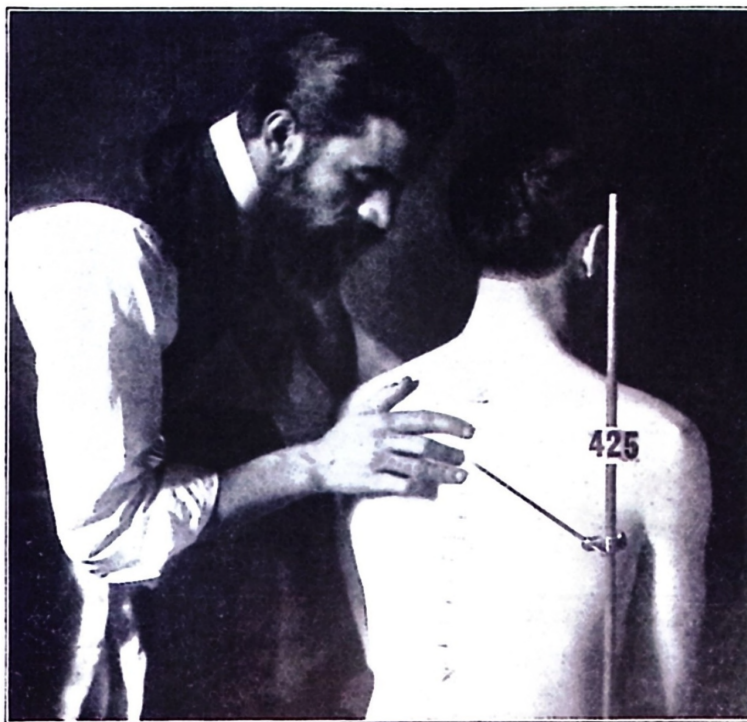


Fig. 250.

#### 4. *Subluxations, described and illustrated.*

In all subluxations there is more or less abnormality of position. If the circumstances indicate the probability of future greater abnormalities (and Innate is the judge) then will utilize its forces to prevent such by the proper placing of mechanical ties, ferrules, bands or piers which will suffice to retain the vertebra to as near normal as possible. This is one of the instances where adaptation follows the circumstances. These supports or braces are the consequence or result of the conditions which necessitated them. As the ankylosis is an accommodation, it is for the Chiropractor to adjust the subluxation and by doing so have no need for the scaffolding or false work which was a necessity then but not now. The process will start by slightly breaking the ankylosed tissue and in proportion to the correction of the subluxation just so far will the exostosis be removed. When the exostosis is builded in great quantities and of large size and of considerable thickness the average physician would make claims that to break it was an impossibility, that the "original bone would fracture before the ankylosis." Usual thinking would confirm the statement, but when it is proven by many clinical cases



such as are on record at *The P. S. C.*, that the first structure is 20 to 30 years in *slow, steady* formation and those fractures are *rapidly* united by callus in 10 to 14 days growth, it will be seen that the later have not the consistency and solidity of the former, therefore is that which loosens its grasp first. In chronic and some acute conditions, where excessive heat or other functions has been or is present, the Chiropractor frequently meets with exostotic growths in many mechanical phantastic forms in and around vertebrae. These are ordinarily simple and easily adjusted, when you know how. The percent of ordinary cases that have exostosis is an almost impossible question to settle. Considering the experience of *The P. S. C.* I believe it could substantiate that 2-3 of the general run of cases have more or less of such conditions present.

5. *Relative position and articulations.*

The juxtaposition of a vertebra with the other is a necessity to have normal position, consequently no pressures upon nerves.

6. *Where nerves are impinged.*

8. *How and what makes pressures.*

These have been covered by the same points in previous vertebrae.

8. *Functions and organs involved. Location of—*

Upon the left side issue those fibres which give transmission to mental impulses controlling the functions of the heart. Upon the right we have no definite viscera except the superior part of right lung, and chest and back region in the immediate vicinity. Sometimes the left lung will be located with its nerves leaving the corresponding foramina, although this is not properly Lung Place.

9. *Adjustments necessary to correct each.*

In the adjusting room respect should be mutual between patients and Chiropractor. Your patient should remain seated for superficial and deep palpation or nerve tracing. When once this has been determined have them stand at either side of the adjusting table, place the knees upon the forward part of the rear section, then easily bending forward, he can, with the hands, grasp the rear portion of the forward section, then letting the chest down so that it rests easily upon the forward portion of your bench. The distance between the two sections is deter-

mined by what portion of the spine is desired to adjust, how much the patient resists, or relaxes, whether there is much ankylosis or not, and thon's size and length. On the average, the wider the division the greater is the leverage for the Chiropractor, and the easier and quicker the results for the patient. Thon may object, thinking he or she will have a broken back, but assurances will soon convince otherwise. After the adjustment, during which you have spoken of thorough relaxations as the greatest help, upon their part, the patient rises squarely *upon his kneces*; under no circumstances permitting any twisting or contortion. In dressing have them be careful not to flex or bend the head, back or hips to any great extent or more than is necessary, inasmuch as the patient can quickly undo all the adjustor has accomplished, if care is not exercised. After dressing see that the patient lies no' less than 1-2 hour in your "rest room." This does not mean that because he lives next door or "only one block away, up stairs or down, that he can go there and rest" for the muscular action necessary to go up or down stairs, into vehicles, or street cars, is often sufficient to jar out of place what you have been correcting.

If you permit such indiscretions it is but a short time until your patient complains of no results and you are held responsible, therefore, you, as the Chiropractor, backed by experience and knowledge about which he knows comparatively nothing, must be firm and hold steadfast to that point. *Results are what must be shown or you are a failure.* Just before giving the adjustment it is well to give a few words of explanation telling your patient just what you intend doing, that it will hurt for a moment and might be attended with girdling pains for a minute or two. By so doing they repose confidence in you sufficient to allow the second adjustment. The first adjustment with a new patient must be a feeler, i. e. you must test him in all ways, find out whether he braces or not, is extremely sensitive or not, whether vertebrae adjust easily or the reverse, etc., after which you will know exactly what your patient is capable of receiving daily.

In extremely sensitive or chronic persons the work may seem tedious and slow but by care and making movements accurately it will be but a comparatively short time

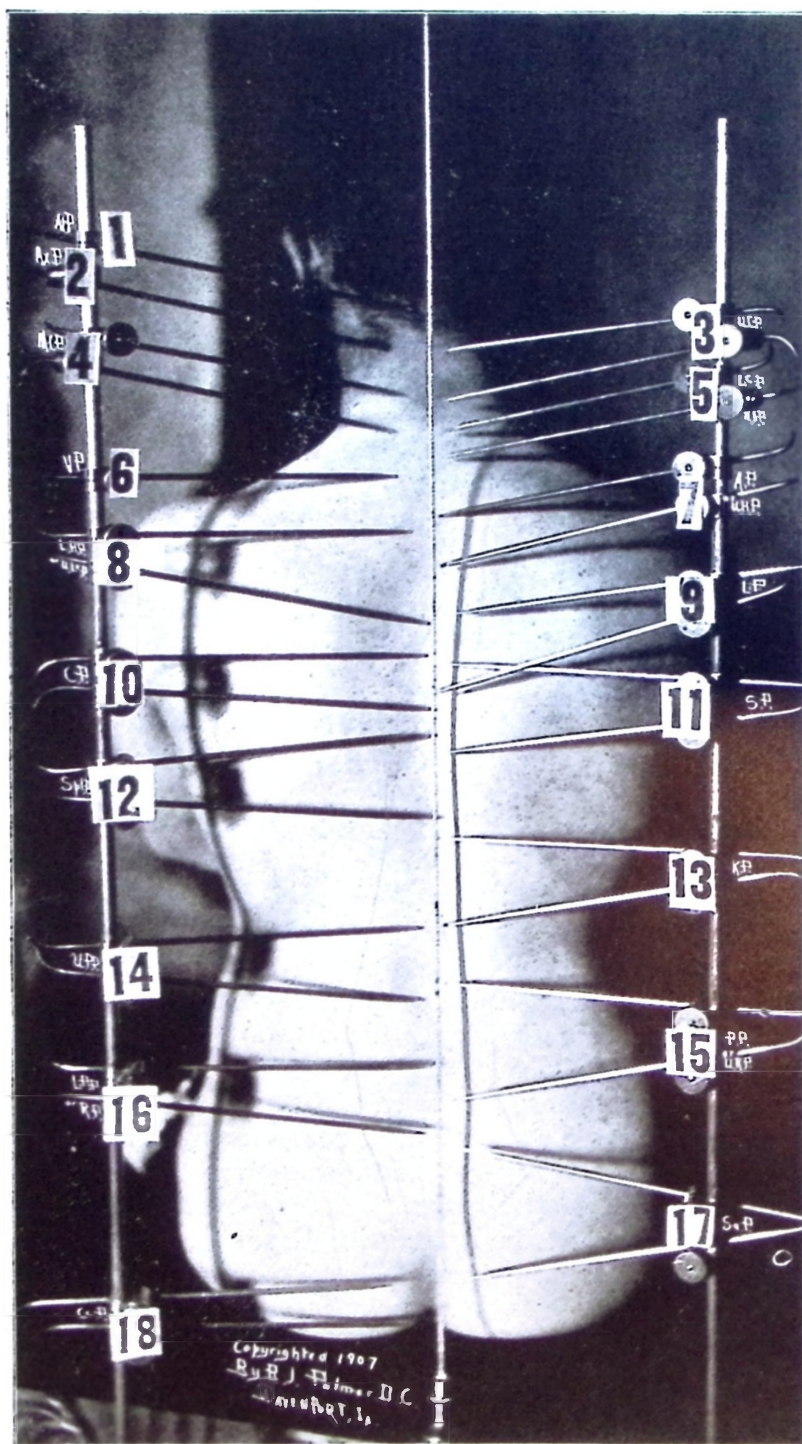


Fig. 251. Composite "Key" as described on P. 192



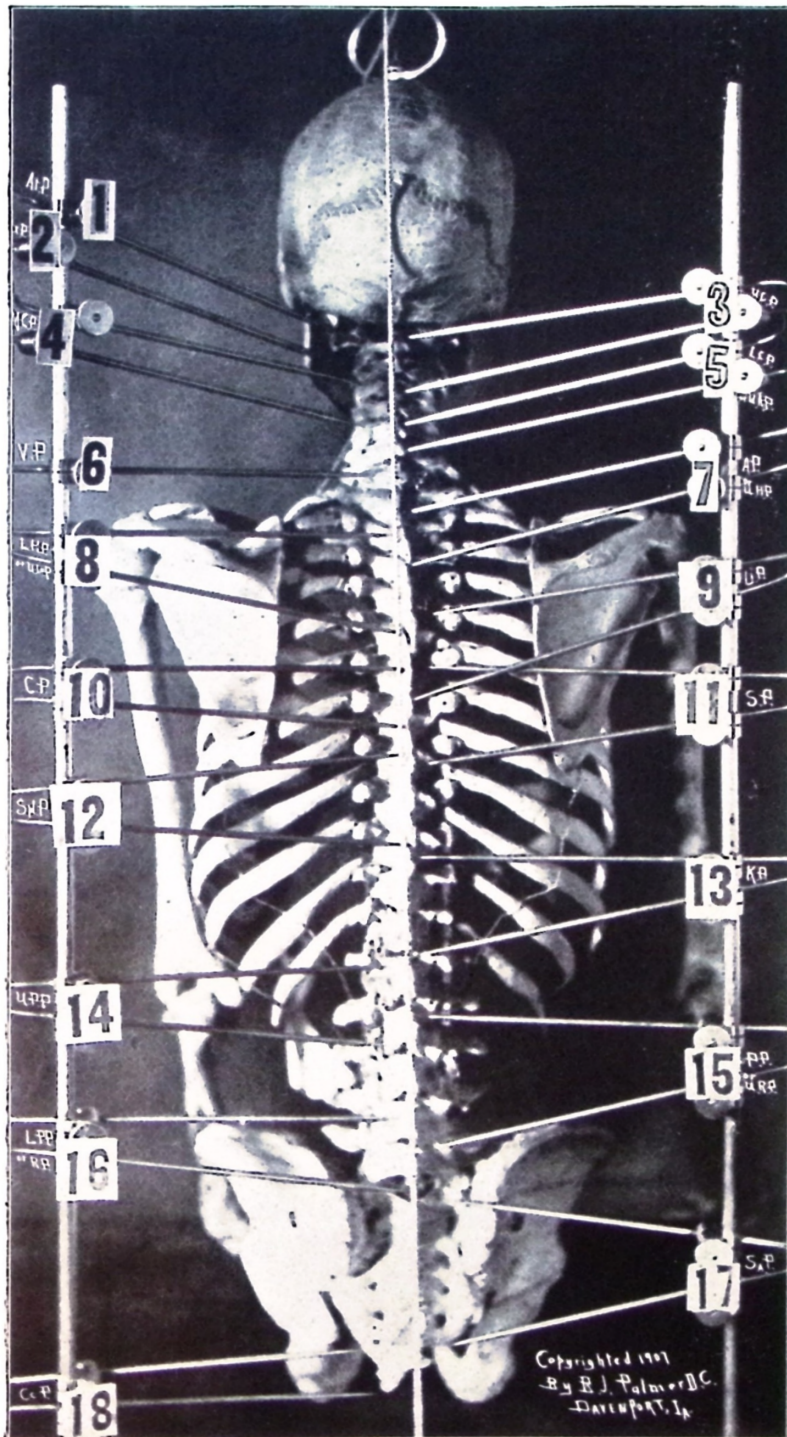


Fig. 252. Composite "Key" as described on P. 192

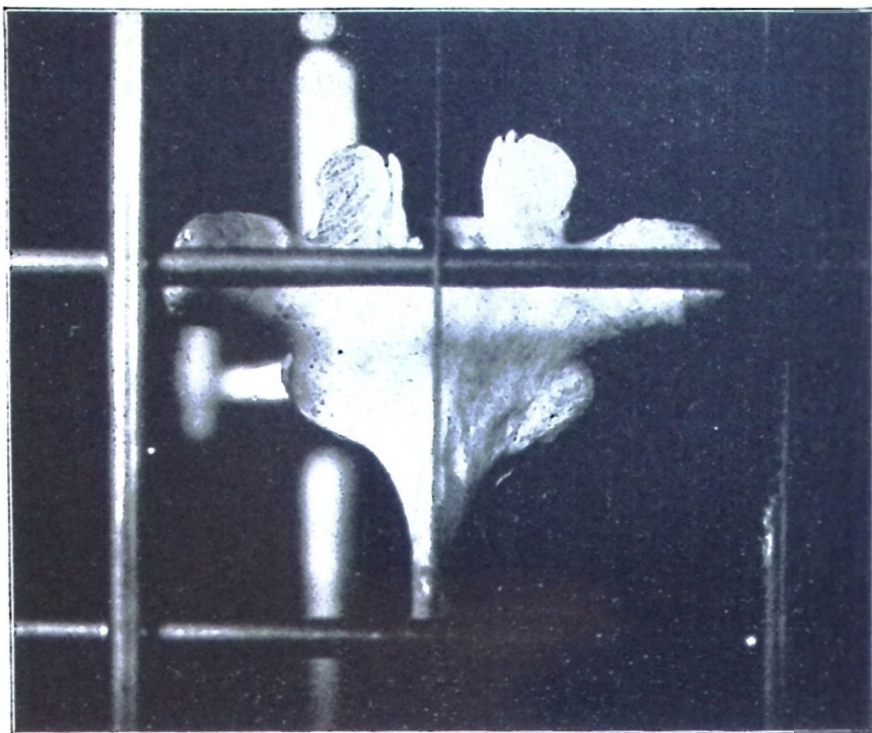


Fig. 253

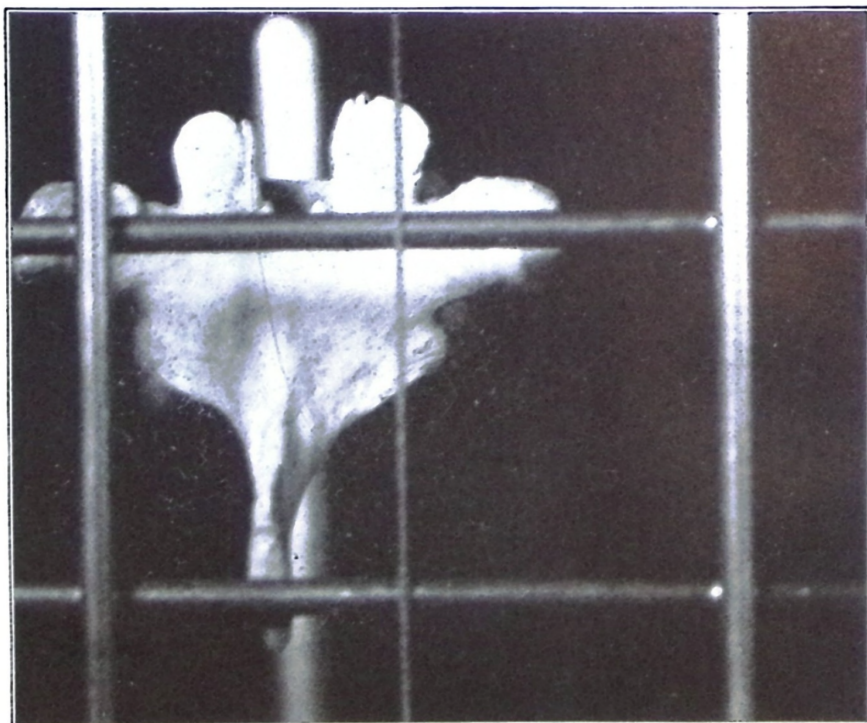


Fig. 254



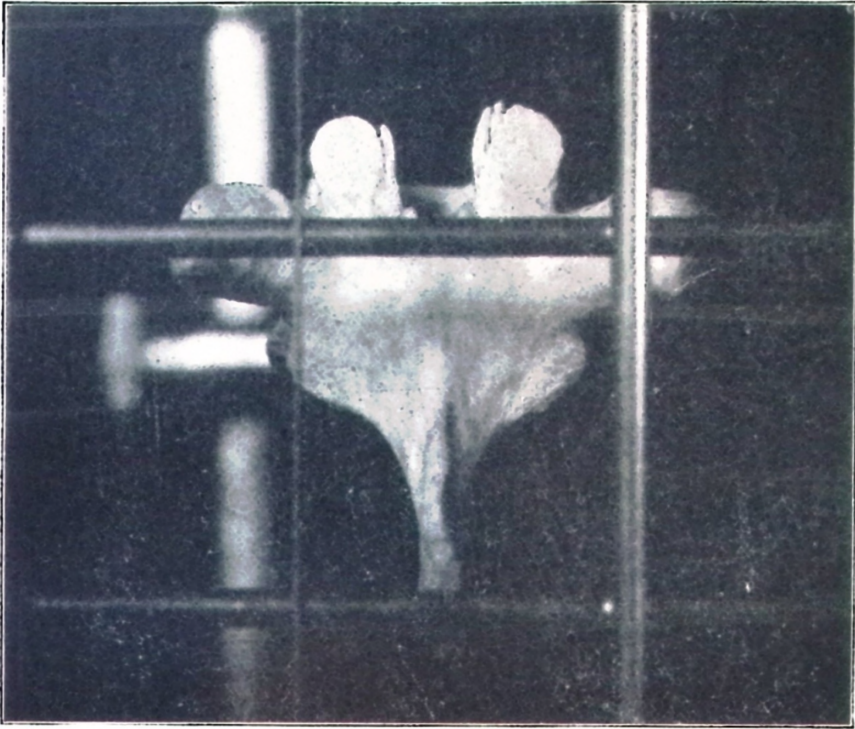


Fig. 255

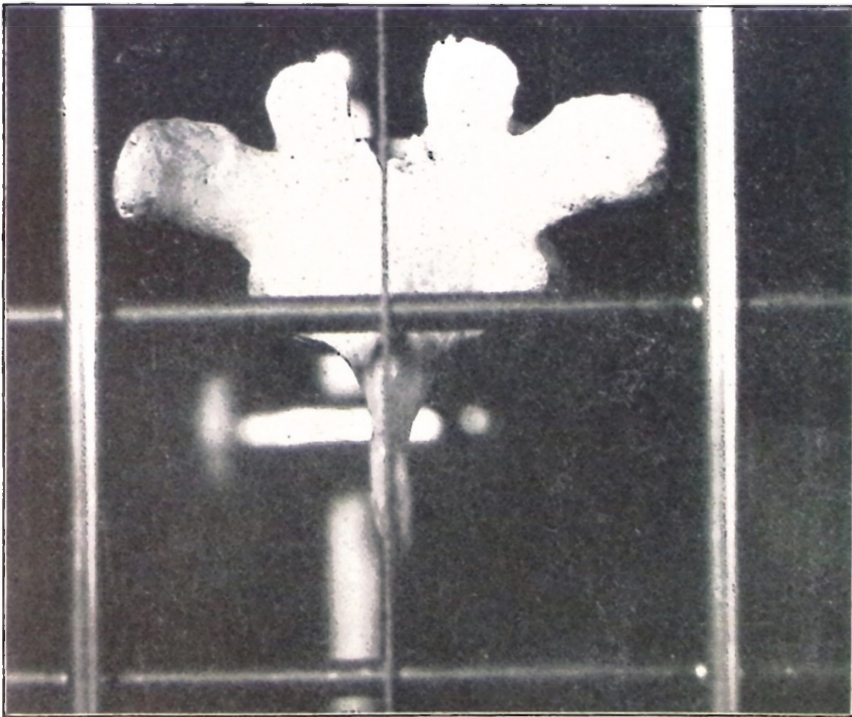


Fig. 256



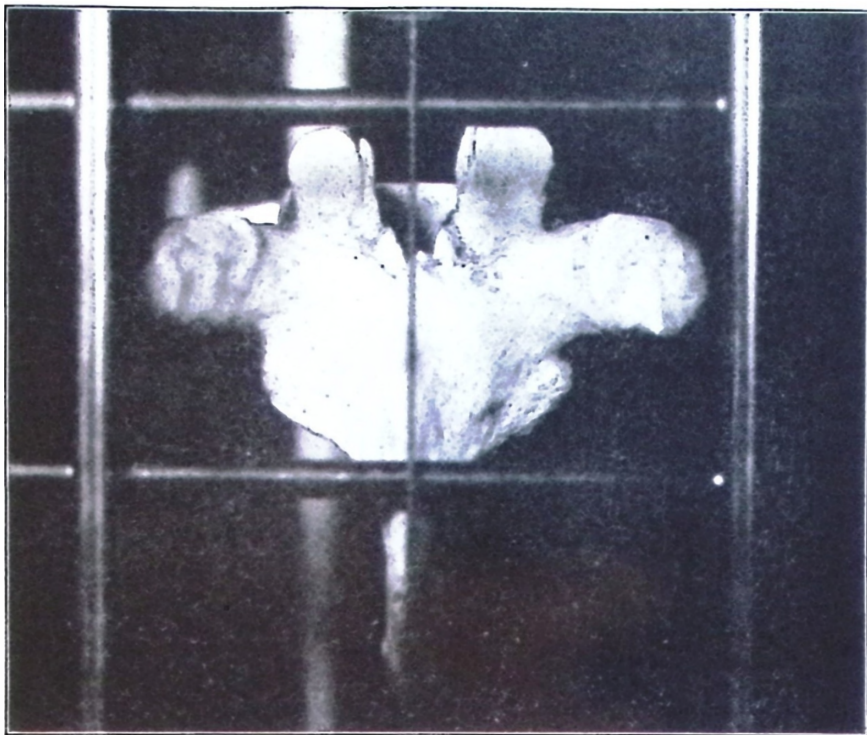


Fig. 257

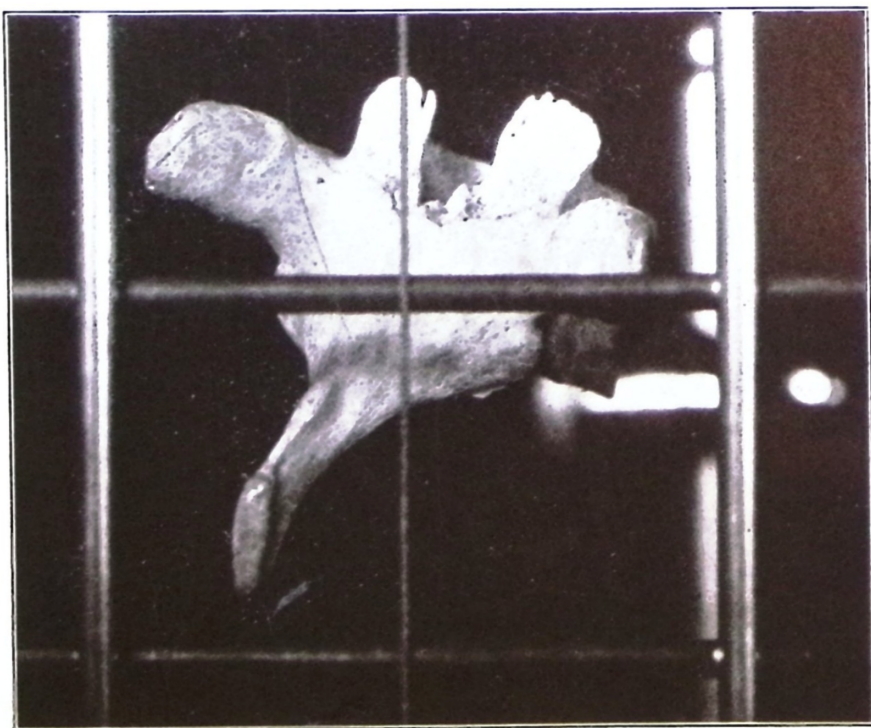


Fig. 258

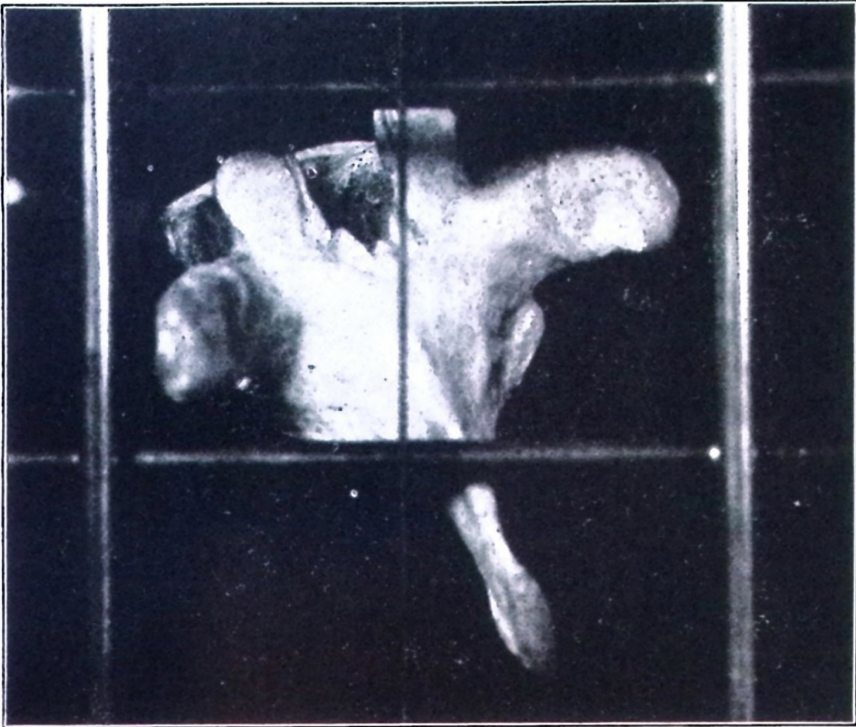


Fig. 259



Fig. 260



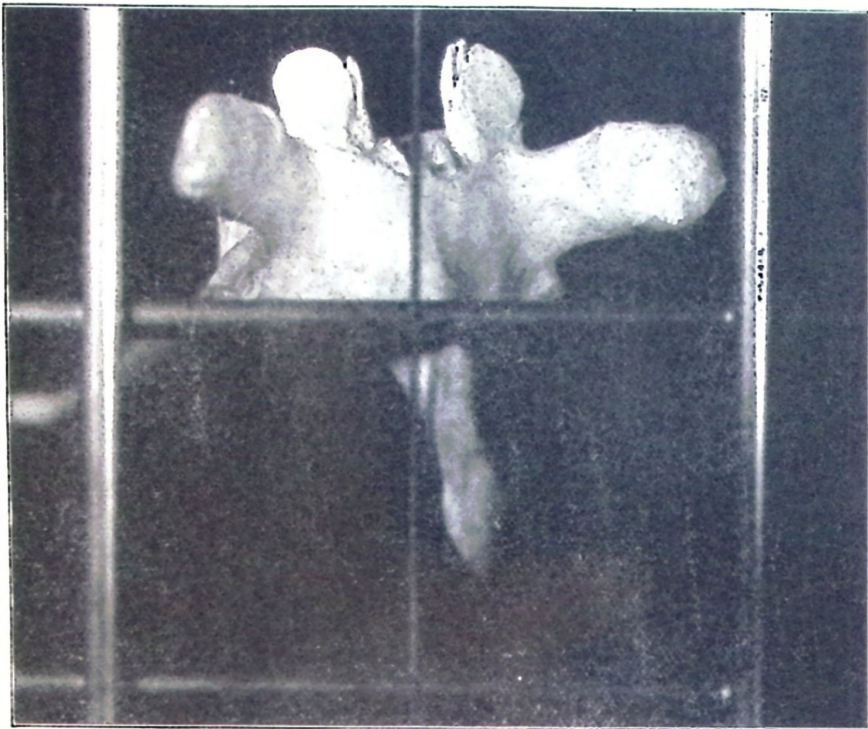


Fig. 261

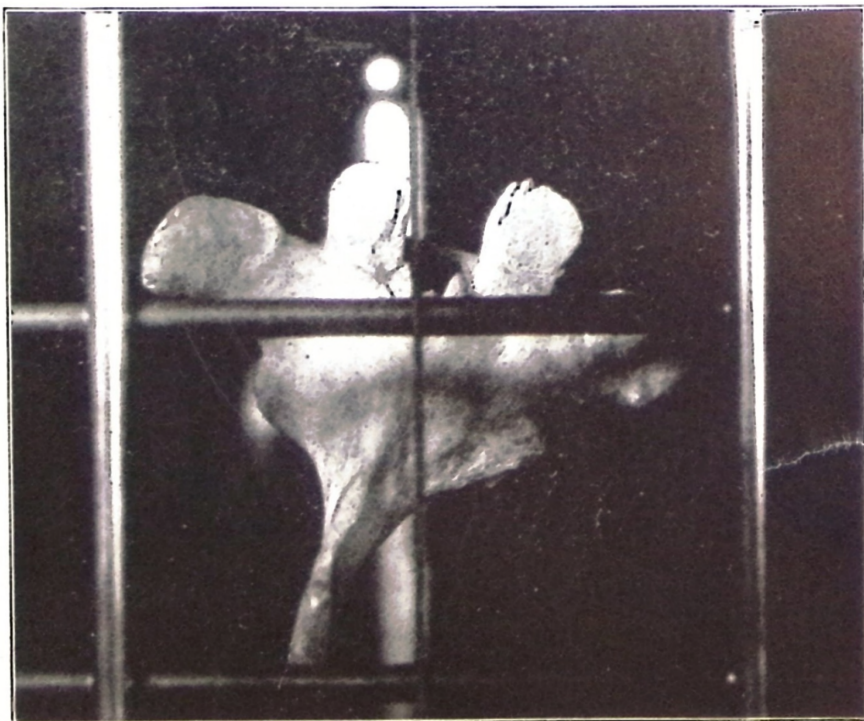


Fig. 262



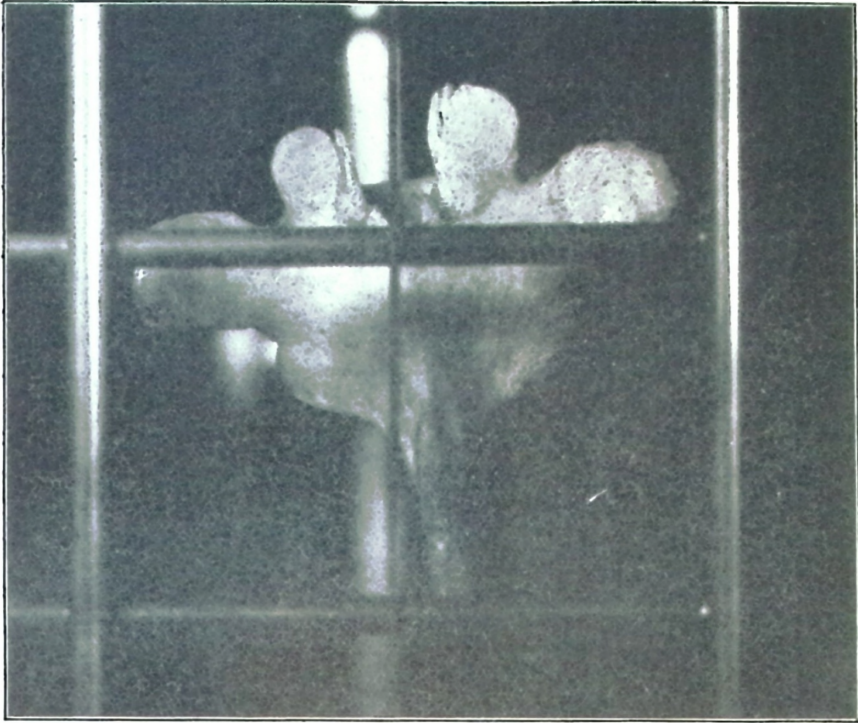


Fig. 263



Fig. 264

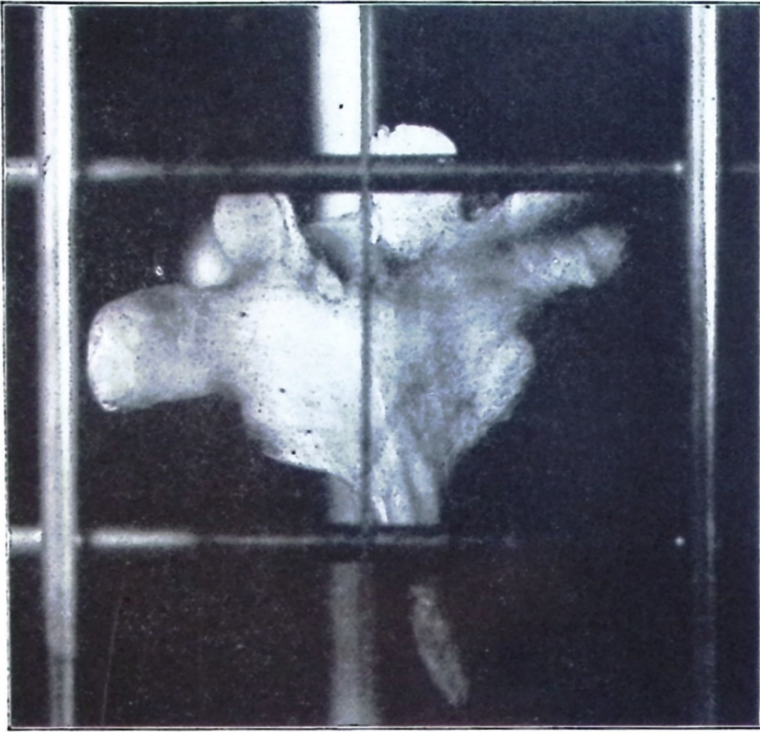


Fig. 265

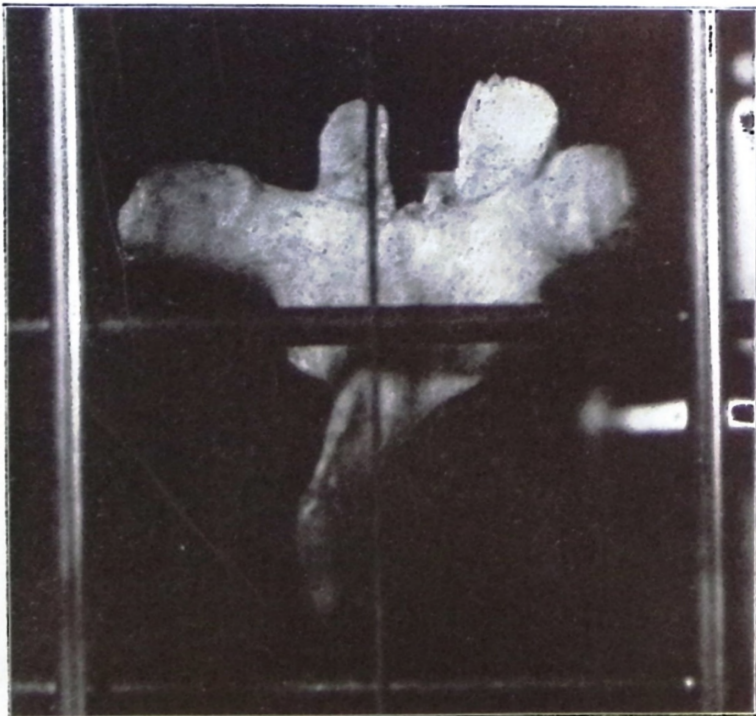


Fig. 266



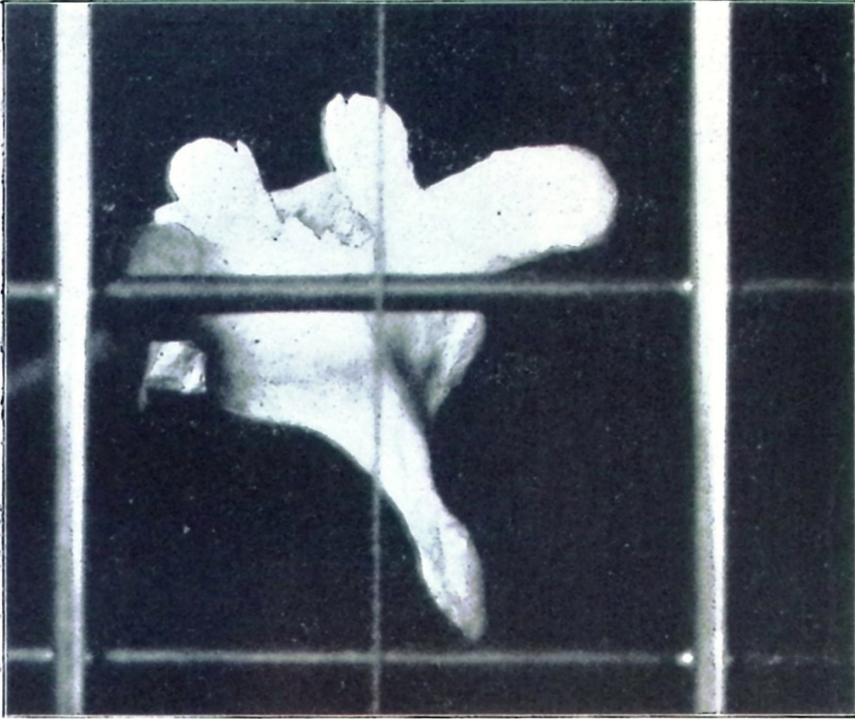


Fig. 267

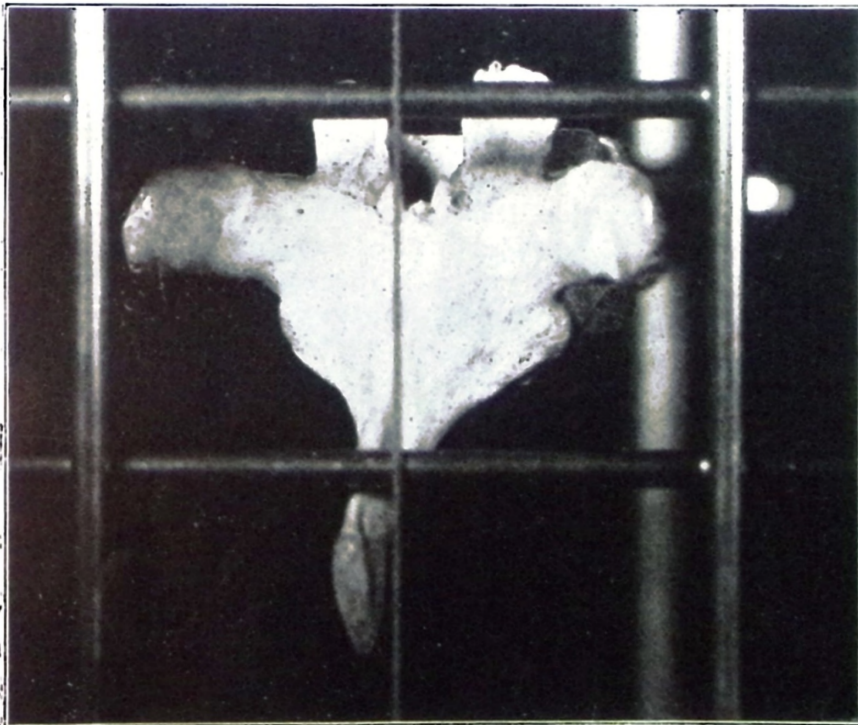


Fig. 268



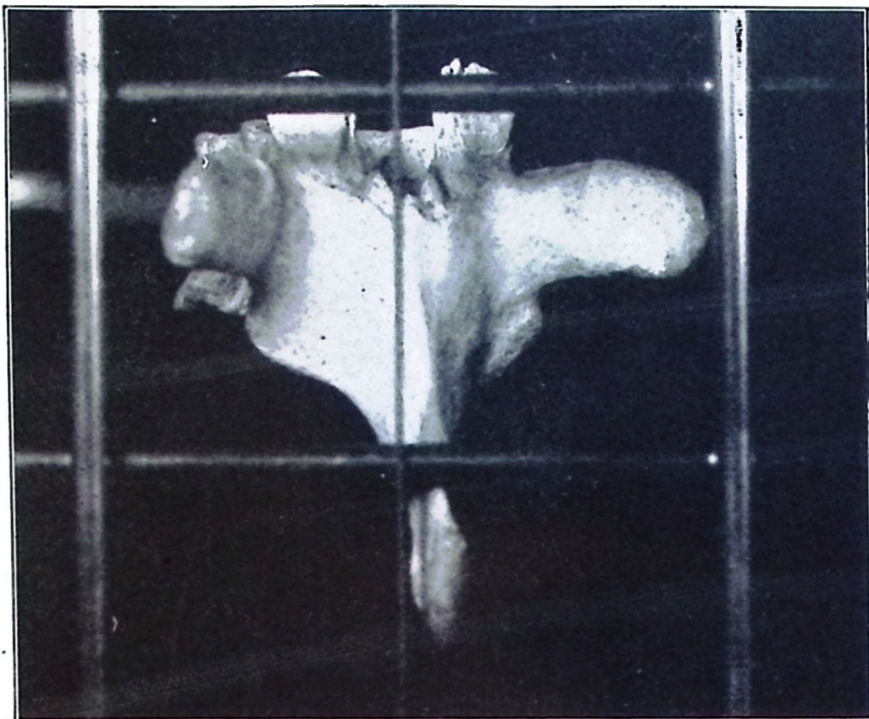


Fig. 269

Fig. 253. In this set of views I have endeavored to draw lines to show the areas that vertebrae will work around. The subluxations are named by where the spinous process is. Note where the spinous and transverse processes are, in this illustration, which is normal.

Fig. 254. *Left* subluxation. The entire vertebra has rotated around its pivot until the posterior is to the left of the median line.

Fig. 255. *Right* subluxation. The opposite of Fig. 254.

Fig. 256. *Superior* subluxation. Notice its position, in relation with the cross bars as compared with the normal.

Fig. 257. *Inferior* subluxation. The opposite of the preceding photograph.

Fig. 258. *Left superior* subluxation. In this we have a combination of the left with the superior. While the position is exaggerated yet it is in accordance with many curvatures met with in our work.

Fig. 259. *Right inferior*. The direct opposite to the preceding one.

Fig. 260. *Left inferior* subluxation. It is well to refer to the normal occasionally so as to fix in your mind where it is abnormal in comparison with the cross and perpendicular bars.

Fig. 261. *Right superior* subluxation. The subluxation is determined by the abnormal position of the spinous process.

Fig. 262. Spinous process *left*. Left transverse superior. Right transverse normal.

Fig. 263. Spinous process *right*. Left transverse normal. Right transverse superior.

Fig. 264. Spinous process *left inferior*. Left transverse slightly below normal. Right transverse inferior.

Fig. 265. Spinous process *right inferior*. Left transverse inferior. Right process slightly below normal.

Fig. 266. Spinous process *left superior*. Left transverse superior anterior. Right transverse posterior superior.

Fig. 267. Spinous process *right superior*. Left transverse posterior. Right transverse superior anterior.

Fig. 268. Spinous process *left inferior*. Left transverse inferior anterior. Right transverse inferior posterior.

Fig. 269. Spinous process *right inferior*. Left transverse inferior posterior. Right transverse inferior anterior.

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until satisfaction in delivering good work, will be with you and the patient. In delivering adjustments to infants remember the age with which you are working. The child's spine is more pliable, and plastic, therefore the greatest care should be shown. It is better to have the mother leave the room, not that she may learn some idea, but the mother's love will often rebel against the adjustment for fear "you might seriously injure her child."

The manner of procedure is undoubtedly new to her, therefore fear is her uppermost thought. To have her present means that she will continually repeat "now don't

press so hard, you will break my baby's back" etc. All are points upon which you do not want nor need dictation. What the mother does not see cannot hurt her. The adjustment, given to the child, makes the mother suffer more than the child.

The spinous processes in children's subluxations are usually pointed out and referred to by parents and medical advisors as normal. Early correction will avoid future years of discomfort and suffering. All good things can be overdone. As with the Indian, who remarked, "Negro like bread black, white man want it like dough, Indian he want it done just right-done brown. "So in adjusting there is a happy medium upon which the best results can be secured. This is determined by good training, proper Chiropractic education, good judgment and knowledge in observing your patient.

Where excessive heat is involved, the object is to have this reduced with your adjustment; once each day has been determined as the best result giver; in some extreme acute cases 2 or 3 times may be permitted providing a period of 6 hours elapse between. Usually in chronic conditions, more than once each day intensifies, creates more heat and makes worse what you are aiming to make better.

As each adjustment is given daily, see to it that it "goes" *the first time*, do not get into the damaging habit of punching 2, 3 or 4 times in succession without knowing something has been accomplished. If there is any one habit that is more dangerous and damaging to your success and the patient's welfare than others, it is giving the 2d or 3d punch on top of the first in order to try and get the vertebra to move; you but wedge the vertebra in its abnormal position that much tighter and increase the quantity of heat, and consequent damages are more noticeable. *Do it right first and then let it rest.*

#### 10. *How to give adjustments correctly.*

Some of these pointers have been given under point 9.

#### 11. *What means, and portions thereof, to use.*

This has been thoroughly carried and elaborated under several vertebrae previously. I believe in brevity where



possible. Give a valuable idea and knowledge with few words.

12. *What diseases to adjust the third dorsal for.*

The diseases to adjust the 3d Dorsal for would not greatly vary from those enumerated under 2d Dorsal. As a general rule we can maintain that each nerve or pair thereof as they leave the spine have a certain prescribed transverse section over which their functions are conveyed.

The diseases would be of heart, upper lungs or lower bronchial tubes, including asthma. Pectoral or superior back region in any of the many diseases which frequent these areas. In one reported case decided results were noticed in deafness from adjustments at this region. This is rare but worthy of mention for it is the freaks that make failures unless we prove to be informed.

## CHAPTER 15.

## 4TH DORSAL.

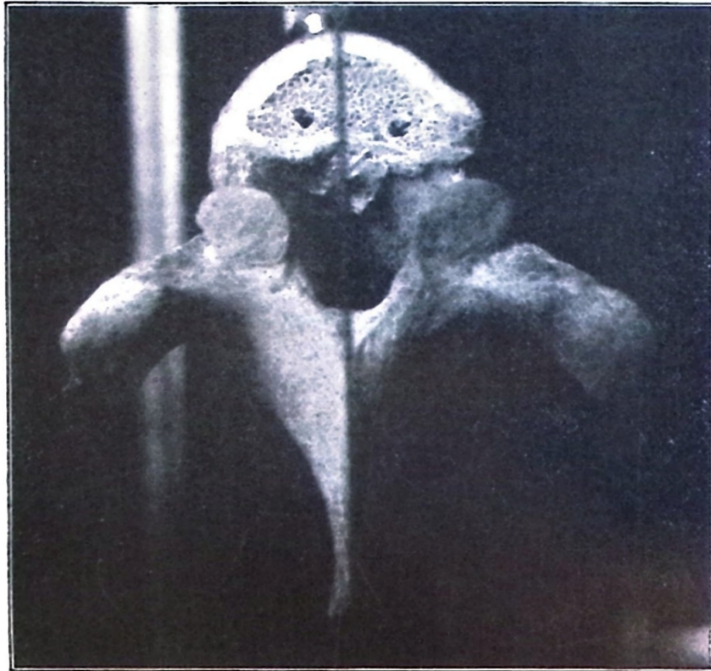


Fig. 270

1. *Vertebrae and its title. Lu. P. or U. Li. P.*
2. *Superficial palpation and landmarks.*

In palpating tender nerves it is rare to realize that "sensations pass up a nerve." The "feeling" may be of that character but remember that impressions (whether normal or abnormal interpretations, as in pain) are but the mental interpretation of normal or abnormal physical conditions.

The spines of the scapulae can be felt through the skin, and when the arms are crossed upon the chest they correspond to the level of the 4th Dorsal spine and ascend outwardly to the point of the shoulders.

The fourth Dorsal spine indicates the position of the base of the heart. With a vertebral column in hand you will observe that the posterior prominent features are the spinous and transverse process. The latter vary in their

location in comparison with the spinous process of the same vertebra. The only palpating points for these are Atlas, 1st Dorsal to 10th Dorsal and 1st Lumbar to 4th inclusive.

The 11th and 12th Dorsal usually have minor transverses. The 5th Lumbar is usually well crowded upon the alae of the sacrum.

Palpate thru muscles lying in each lateral groove and slightly anterior to them will be found the transverse processes.

In the dorsal they will be found lateral and slightly superior to the spinous.

3. *Normal position and articulations.*

While the spinous process is reliable in determining the position of that vertebra it is by a no means uncommon condition to find vertebrae with bent spinous processes. This might be due to direct blows or falls.

To know definitely that such is the case find both transverse processes of *that* vertebra and compare with the spinous process. This will determine accurately the fact.

4. *Subluxations described and illustrated.*

This has been carried. The nearer the 12th Dorsal is reached the greater is the liability to subluxations.

5. *Relative position of adjacent vertebrae*

6. *Where nerves are impinged.*

7. *How and what makes pressure.*

Have been carried.

8. *Functions and organs involved.—Location of—*

There being but 7 primary functions in a human body it can be readily seen how, if these were placed at any specific locality there might exist any combination of abnormal functions in that region. Fourth dorsal foramina is primarily the gateway of functions going to the lungs, chest, muscles and ribs. If the brain nerves going to these tissues are impinged with one or more functions it can be readily seen that any kind of a disease would and could exist at their peripheral. The superficial posterior region is as a rule, regulated by the impulses expressed, which come from vertebrae higher. Immediately following subluxation there is pressure upon fibres and disturbance of impulses, to a greater or lesser degree, follows.



a time at least. If you watch your patient discriminat- ingly you will notice the tendency to retrace the identical grades thru which the disease has passed. It is true one step may be more lively or active than its progressive mate was the opposite way, the fever or excessive heat will re- turn but instead of being fever it will be a period of in- creased normal heat, thus step by step our retracing proceeds and it is during these peculiar conditions that even the most thoroughly posted patients will sometimes get discouraged and wish to dispense with your services. It is at this time that this explanation will come to your rescue. This applies to those cases where sublaxations have made abnormal the shapes and forms of verterbrae, this may be in acute or chronic diseases although if our success lies in getting the acute conditions we will not be so likely to find the above. In chronics it will hold good.

The explanation is offered that as the sublaxation pro- gresses it is gradually increasing the pressure consequently the various gradations and colorations of diseases become more manifest. Adjustment is in the reverse order and that in proportion as it is replaced and rebuilt, pressure becomes lighter, hence the retrogression in reverse order to what it came. Exceptions to this rule would be in those acute or chronic conditions where the vertebrae are not deformed and are replaced by a few adjustments and re- main, quickly returning the abnormal functions to normal without going thru the successive stages.

9. *Adjustments necessary to correct each.*

Chiropractic is primarily the philosophy of cause and the science and art of adjusting those vertebral sublax- ations which are the physical representatives of the causes of all diseases. It is not for me to state in what propor- tion of patients having diseases Innate corrects the cause, but thou does adapt herself to the circumstance in all cases to a greater or less degree.

The percentage of sublaxations that are brought on during sleep while in frights, dreams or night mares is undoubtedly large and the proportion of diacinemiae that are corrected during sleep is also larger than we can imagine.

We recognize many persons who retire well and wake in the morning *with* a headache which one Chiropractic ad-

justment at once, will correct. Many a patient produces a crook, wrench or twist during the day, retires and wakes the following morning without it. Very evidently the complete relaxation necessary to induce sleep is sufficient to allow Innate to draw the vertebra or vertebrae to normal position. In very slight, recent, sublaxations this is a demonstrated fact, but it is in the more severe types that Chiropractors are called to adjust, for they are obstacles that Innate cannot overcome. Many instances have been brought to my notice of cases who have been injured, diseases produced, and causes corrected by accidental means. One peculiar fact is that *the accidental adjustment* will accomplish more with one violent move, taking one moment, than we can with the philosophy and art of days or weeks of time. Why? See article on "Recoil" under Chapter 13.

10. *How to give adjustments correctly.*

The position of the patient on the adjusting table has much to do with the success in replacing sublaxations. There is one median place on the chest for placing the body on the rear portion of the superior table.

It would not be on the breasts nor low on the sternum but at the junction or a trifle below where the manubrium joins with the clavicles. This gives good support and retains the thorax on the table in adjusting lower vertebrae and gives a solid base for upper dorsal adjustments.

11. *What means, and portions thereof, to use.*

In giving adjustments *relaxation is the main object*. It may be necessary to divert your patients attention upon other things, than what you are going to do. Ask "How old are you?" "When is your birthday?" or have the patient draw in a deep breath and let it out quickly, and many similar questions or actions can be asked for and the moment of answer is your psychological time. At all times though you must watch the patient carefully so as not to attempt adjustments while he is braced or contracted as you will then but make things worse.

Machines, like human machines, live, act and express themselves with characteristic degrees of speed. Men, like machines put into action a regular impetus or momentum of power. This is a fact, normal or abnormal. Disease progresses with relative degrees of momentum. To expect to always immediately check the momentum of any chronic disease the first day, hour or minute is too much. It can be and is done in acute cases but not always with the former. It may take a day, week, month or several of them to check this onward pace, then when the abnormal momentum has been stopped it will take time to create the reversed type of impetus. At first it begins slowly to pull up hill, gathering progressive power as foramina are opened and current restored all for the betterment of man.

Even though the power be reversed in an engine upon the tracks it will "skid" a long or short way, before it comes to a standstill and then the reversed action begins. Keen insight and knowledge of the philosophical workings of man reveals the same to us.

Discouragement is paramount at and during the time of the impetus slacking. Then is when you must exert your hardest efforts to convince your patients of the injustice they do themselves. They will leave just when you have them "coming around the bend" unless you show them the facts in the case.

From that moment onward, disease progresses in a certain manner and degree, expressing peculiar individual characteristics. Countries, States and Cities show characters and are of various types, differing as so many people. When disease is as exhaustively investigated the same remains apparent. The disease in each person has certain speeds at various times with which it is destroying the usefulness of the party involved;—for instance "A" and "Z" would be the points of health. At "A" is the time of subluxations. The various steps between "A" and "M" are the progression of the disease. I have yet to notice one case that, sooner or later, does not show these tendencies. It may take close observation to reveal them but they are there.

"M" is the point of crisis and is it at this stage that we, as Chiropractors will receive the majority of patients, for



12. *What diseases to adjust this, 4th Dorsal, for.*

Pneumonia, Pleurisy, Empyema, Emphysema and Consumption, Rheumatism of chest muscles and upper posterior back superficial region or any other disease of the upper chest or back. Vol. 4 goes into thoro detail on this subject.

## CHAPTER 16.

## 5TH DORSAL.

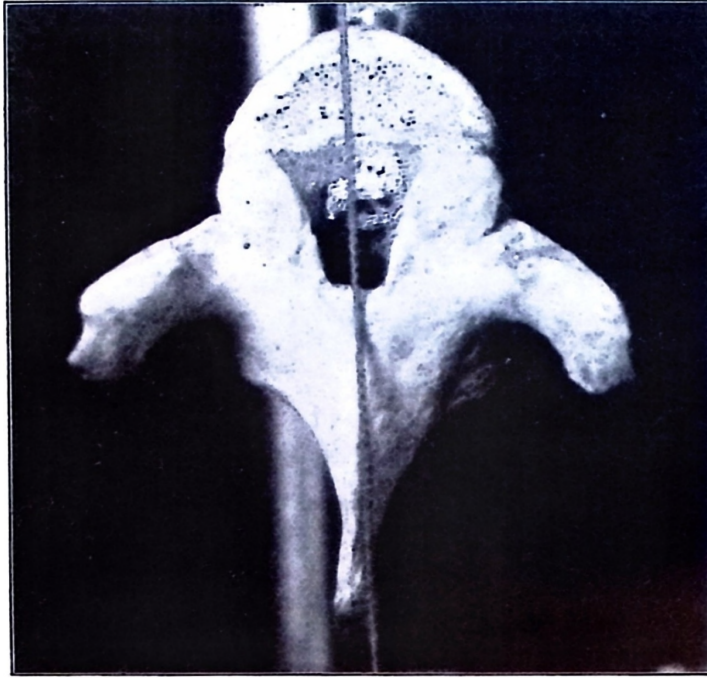


Fig. 271

1. *Vertebra and its title. Li. P. or C. P.*
2. *Superficial palpation and landmarks.*

Comparison is but the consideration together of 2 or more objects. Superficial or deep vertebral palpation is the comparison of relative positions of two or more vertebrae at one time. To consider one vertebra without its relative positions of parts above or below would be incomplete and very inaccurate. To know that one building is higher than another is but to compare them with one or more of the senses with each other. In spinal examinations the 1st, 2nd and 3d fingers should be always used together so that when "running a spine" the 2d finger can feel and be on the process (See Illus. 603) while the 1st and 3d are in spaces above or below. After determining, in this manner, whether superior or inferior, use the same methods on either side of the column to approximate positions laterally. (See Illus. 604 and 612.) This will be

accurate work through comparison. The combination of superior or inferior joined with right or left lateral and the knowledge that all are posterior quickly shows the position and direction of adjustment.

3. *Normal position and articulations.*
4. *Subluxations, described and illustrated.*
5. *Relative positions of adjacent vertebrae.*

Answered in point two.

6. *Where nerves are impinged.*
7. *How and what makes pressures.*
8. *Functions and organs involved. Location of—*

To the right of this vertebra is located approximately the center of the liver. The nerves going to that organ will be found issuing upon that side and may vary slightly in the position of the vertebra in being one above or below this number. It will be well to also remember in this connection that the gall bladder is reached from here.

9. *Adjustments necessary to correct each.*

The general principles previously explained and illustrated are applicable here.

10. *How to give adjustments correctly.*

Suppose two or more spinous processes were very closely approximated making an acute kyphosis. What adjustment would be given?

In such an instance one or two spinous processes placed apart from each other would be *posterior* to the others of that bend. It is from these that you must palpate, study positions and adjust according to your analysis. Unless the case be a severe one the approximation and posteriority determines the adjustment regardless of how many may be together.

How many cervical, dorsal or lumbar are we justified in adjusting in one region each day? While the student knowing his goods is anxious to have the patient up and doing, his over anxiety often leads him into serious predicaments due to damage or failures, the result of his over ambition to push Innate. Your sole and only aim is to restore function, not to create or push.



*Do not overdo. Better underdo than do too much.* The student may be justified in adjusting one vertebra where two vertebrae approximate each other, but more than this will spoil the *individual* adjustment delivered above. When you realize that vertebrae revolve and flex upon joints and each one is a unit you can know when two or more successive ones are adjusted serially that you destroy the value of the position of the vertebra above which you have just replaced.

Close palpation will reveal one or the other as being slightly more posterior than the other and that is the one you must work with. The Atlas, 4th and 6th cervical vertebrae might be adjusted one at a time, more than that would not be justifiable. The dorsal adjustment would vary, according to the diseases of the individual, but never closer than every other vertebra. The closer you adjust, the less results will be ultimately manifested.

11. *What means and portions thereof, to use.*

12. *What diseases to adjust the 5th dorsal for.*

Abscesses, acute or chronic, Excessive Heat, Hydatid Tumors of, Liver spots, etc., are diseases of liver and are corrected at this region.

Many general symptoms have a common origin from this subluxation such as some types of excessive heat; hemiplegia, either side general debility or, what is called, "nervous prostration," "nervous asthenia," etc., also types of general interference with serous tissues as would be found in anasarca and seroedema, this is of course in combination with K. P. subluxation. Vol. 4. *Causes Localized* takes this phase of the work thoroly.

## CHAPTER 17.

## 6TH DORSAL.

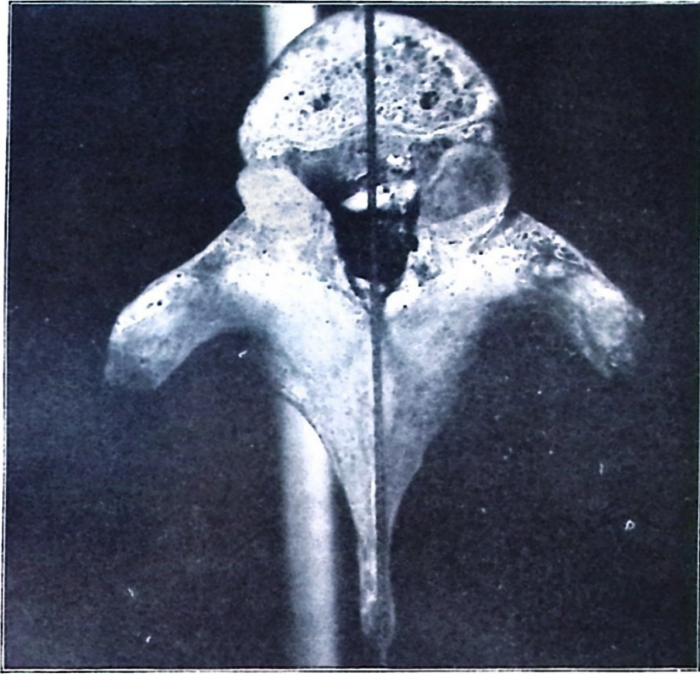


Fig. 272

1. *Vertebra and its title. C. P. or S. P.*

According to the arrangement of localizing the back into zones, 5-6 are C. P. and 5-6-7 are S. P. Therefore if the nerves during embryonic life are differently segregated, the 6th dorsal might be a lower C. P., upper S. P. or S. P. proper. These are points that are determined by palpation, tracing nerves and your analysis.

2. *Superficial palpation and land marks.*

Aside from counting downward, there is no exact method of locating this vertebra. It has no relationship to any other, as regards its landmarks unless you compare the 4th Dorsal spine as given in a previous chapter, and count downward. In general spinal constructions the body must be watched to compare the relative lengths of

different persons. One spine may be 30, 32 or 33 inches in length. Proportionately this may have grown faster but nevertheless it may be a fooler unless you reckon with the added length in your approximation of regions.

3. *Normal position and articulations.*
4. *Subluxations described and illustrated.*
5. *Relative position of adjacent vertebrae.*
6. *Where nerves are impinged.*
7. *How and what makes pressures.*
8. *Functions and organs involved. Location of.*

With this vertebra (S. P.) we have a peculiarity. Upon the right side fibres branch that can be traced under right scapula, axilla and in front of chest up to head, throat and neck regions.

Oftentimes tracings may lead perpendicularly after leaving the foramina and run directly upward to the throat. This location includes all functions of all organs in alimentary tract from lips to small intestines. Upon the right taking from the lips to cardiac orifice of stomach, upon the left taking the balance of this tract. The functions would be general and similar to those portrayed at length before.

9. *Adjustments necessary to correct each.*

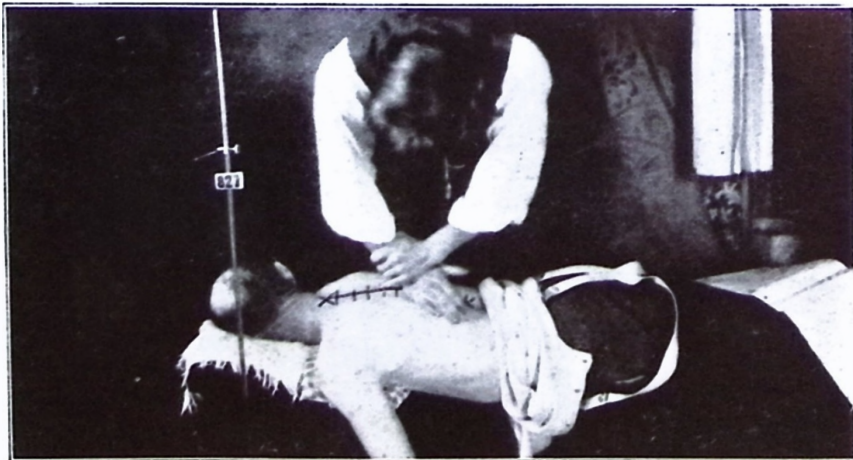


Fig. 273



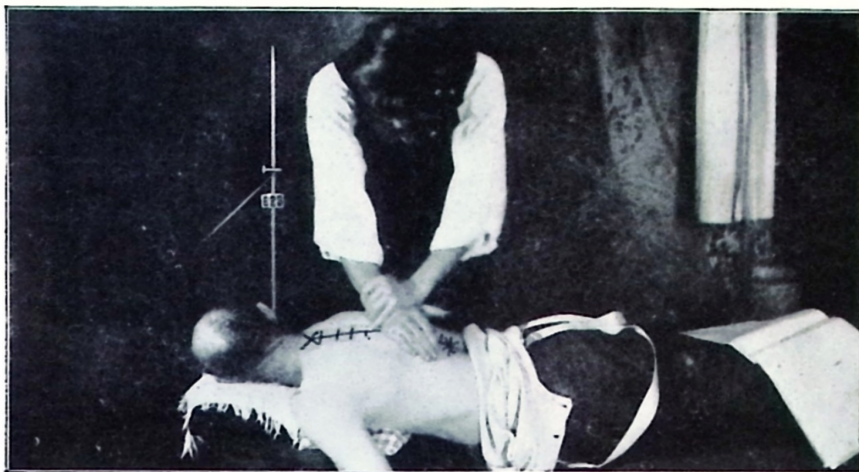


Fig. 274

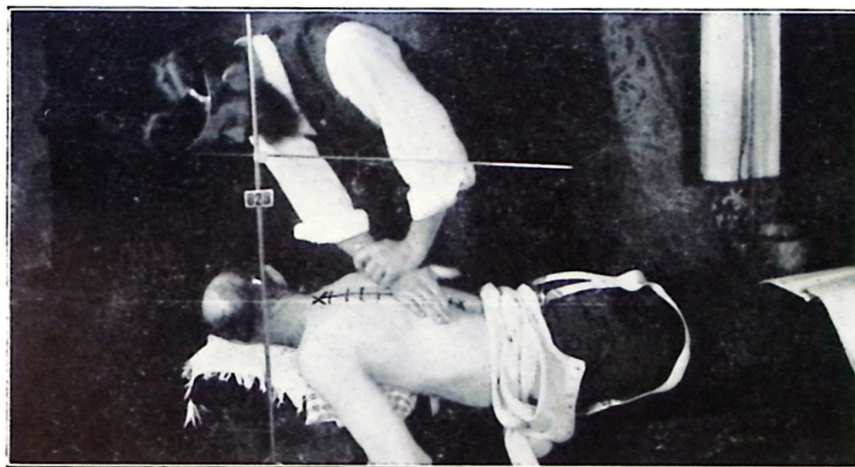


Fig. 275



Fig. 276



Fig. 277

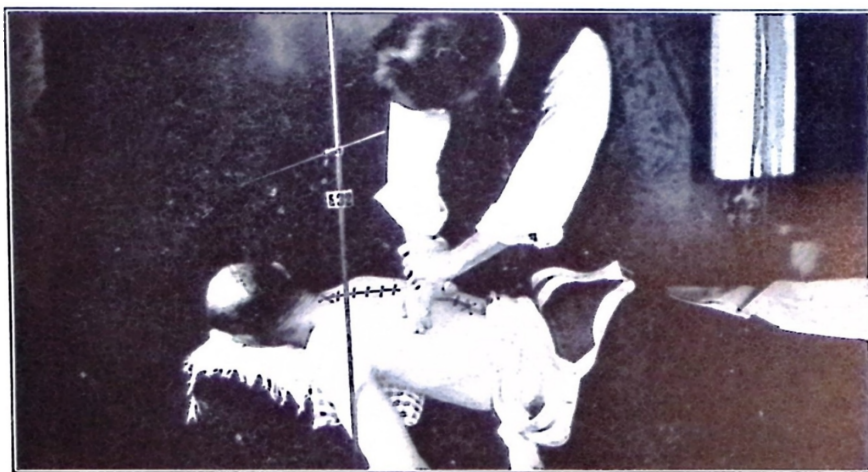


Fig. 278



Fig. 279





Fig. 280



Fig. 281



Fig. 282





Fig. 283

The nearer we reach the center of the spinal column, from end to end, superior apex to inferior base, the easier is the giving of adjustments. The vertebrae are less tightly wedged, more free and less force need be utilized.

Fig. 273. *Left* subluxation and its adjustment of 6th dorsal *to right*.

Fig. 274. *Right* subluxation of 6th dorsal and its adjustment *to the left*.

Fig. 275. *Superior* subluxation of 6th dorsal and its adjustment *to inferior*.

Fig. 276. *Inferior* subluxation of 6th dorsal and its adjustment *to superior*.

Fig. 277. *Left superior* subluxation of 6th dorsal and its adjustment *to right inferior*

Fig. 278. *Left inferior* subluxation of 6th dorsal and its adjustment *to right superior*.

Fig. 279. *Right superior* subluxation of 6th dorsal and its adjustment *to left inferior*.

Fig. 280. *Right inferior* subluxation of 6th dorsal and its adjustment *to left superior*.

Fig. 281. *Posterior* subluxation of 6th dorsal and its adjustment *to anterior*.

Fig. 282. *Posterior superior* subluxation of 6th dorsal and its adjustment to *anterior inferior*.

Fig. 283. *Posterior inferior* subluxation of 6th dorsal and its adjustment to *anterior superior*.

10. *How to give adjustments correctly.*
11. *What means, and portions thereof, to use.*
12. *What diseases to adjust the sixth dorsal for.*

Goiters, affections of eyeball, diseases of throat, including pharynx, larynx, and oesophagus, would be adjusted by throwing vertebra to right.

All stomach diseases, as indigestion, dyspepsia, tumors, cancers, etc. adjusted to left. Variations will be met with where individuals may have nerves impinged on one side or the other; hence, only that side would be normal. If the disease exists on one side only, without the other then that is the side to adjust, or vice-versa. If the patient have throat and stomach troubles, both at one time, then the adjustment would be squarely anterior and superior or inferior as the subluxation would demand.

CHAPTER 18.  
7TH DORSAL.

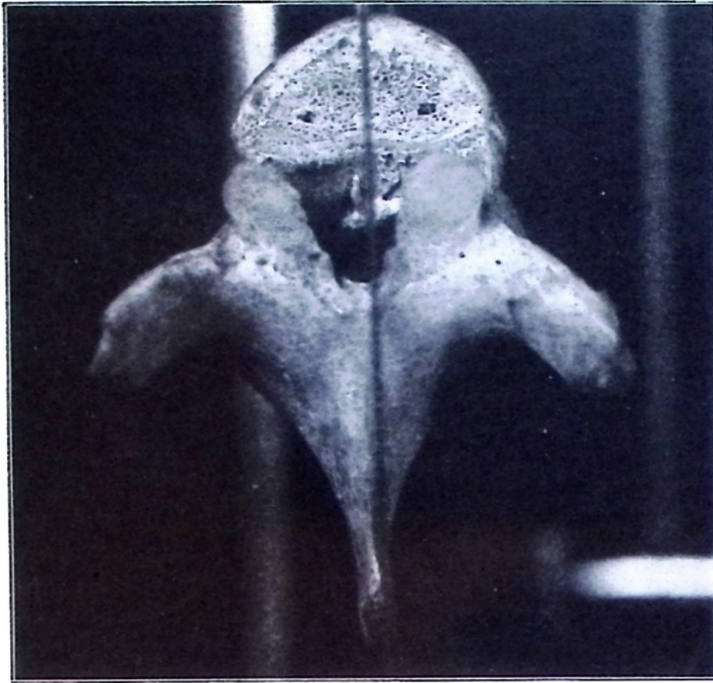


Fig. 284

1. *Vertebra and its title. S. P. or Spl. P.*

According to localization 5-6-7 are S. P. and 7-8-9 are Spleen P. giving the 7th dorsal a lower S. P. or upper Spl. P.

2. *Superficial palpation and landmarks.*

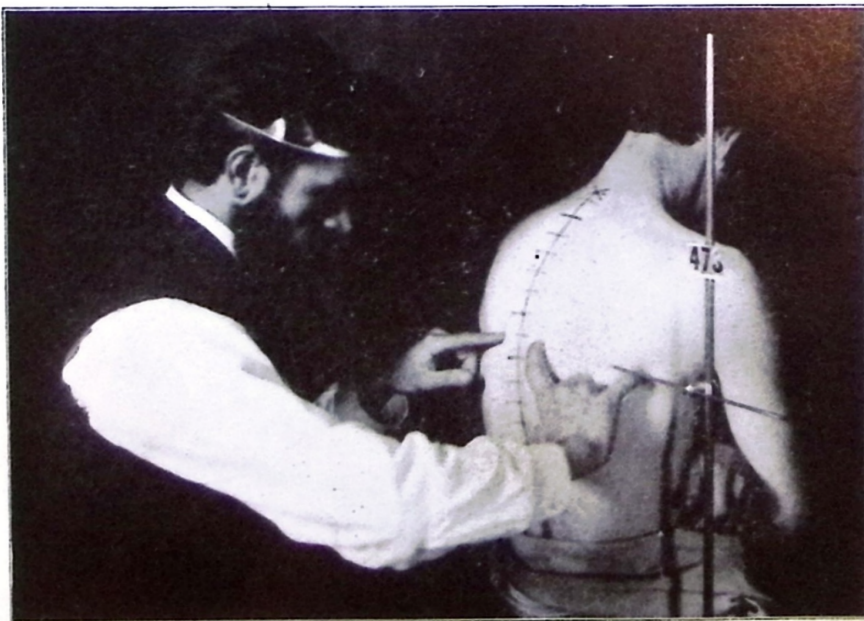


Fig. 285



The inferior angles of the scapulae, when the arms are folded on chest, are on a level with the spinous process of this vertebra. (See Fig. 285.)

3. *Normal position and articulations.*

To Osteopaths it sounds queer to notice the absence of anything pertaining to subluxations of ribs upon their articulations with the vertebrae.

The Chiropractor does not deny that such conditions do exist and are found, but he goes farther by proving that subluxated ribs are an effect similar to a dislocated head of the femur due to contractured muscles caused by subluxation of a lumbar vertebra producing pressures upon nerves. It is not within the province of the Chiropractor to treat effects. The symptoms that follow the subluxated rib are all effects of one common vertebral subluxation.

The force that caused the spinal abnormality was sufficient to twist it from normal, hence its abnormal position and thus is equivalent to changing other surfaces with which it is in contact. The two centra articulations would not be in situation neither would be the zygapophyses, nor transverse articulations. To try and correct the costal articulations to normal would mean to attempt to work on symptoms. Replacing the vertebra (when intelligently done) sets all articulations in proper position. The aches and pains that the Osteopath supposes comes from the subluxated rib are missing as soon as the subluxation is corrected.

4. *Subluxations described and illustrated.*

5. *Relative position of adjacent vertebrae.*

6. *Where nerves are impinged.*

7. *How and what makes pressures.*

8. *Functions and organs involved. Location of—*

The 7th dorsal is Spl. P. indicating the location to adjust for stomach and splenic disorders. This viscera is upon the left side and adjustment according to rules should be toward the organ diseased. As enumerated un-

der point 1 if this be located as S. P. the spleen location would be one or two vertebra lower. In every instance we have generally assigned the locations to zones. If one is found lower than normal the others above or below vary in like manner.

9. *Adjustments necessary to correct each.*
10. *How to give adjustments correctly.*
11. *What means, and portions thereof, to use.*
12. *What diseases to adjust the 7th dorsal for.*

The spleen is the organ secreting splenic fluid which, when it reaches the stomach is gastric juice; therefore, performs an important function, and both must be in unity. The stomach could not maintain its portion of digestion if it lacked this fluid.

It is necessary that its products be equivalent to demands both in quantity and quality. Any function, hindered, in normal action would be equivalent to making the local metabolic processes abnormal. Subluxations, could, would and often do interfere with one or more, or any combination of functions expressed in this organ. Symptoms could be named, but briefly, every abnormality of this organ has its cause at this region. For comparison of diseases listed and localized causes see Vol 4. *Causes Localized.*

CHAPTER 19.  
8TH DORSAL.

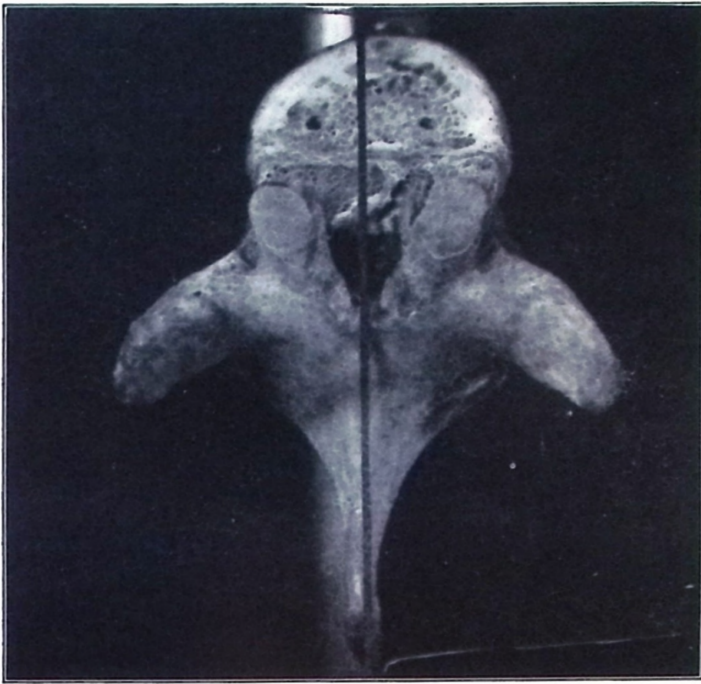


Fig. 286

1. *Vertebra and its title. Spl. P.*
2. *Superficial palpation and landmarks.*



Fig. 287



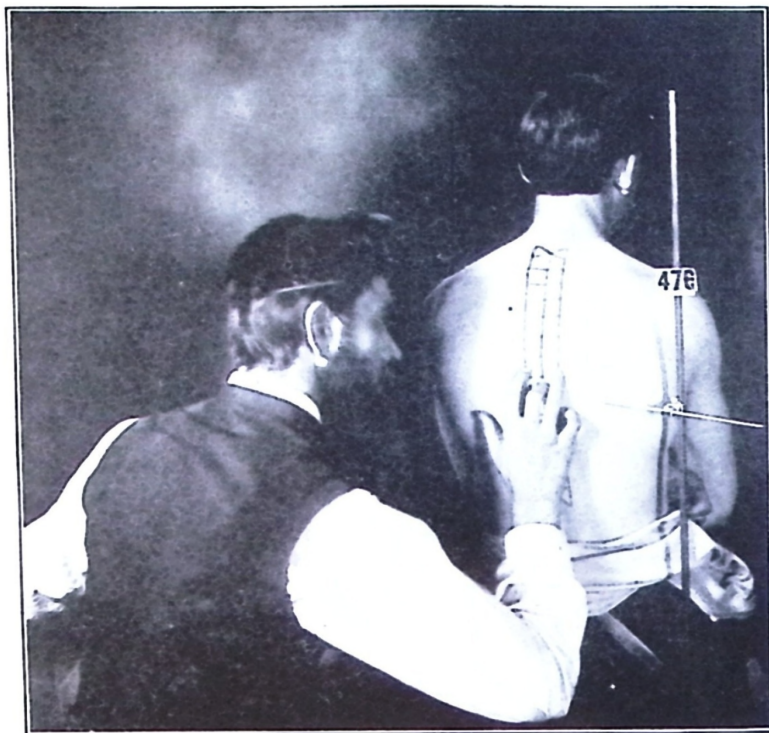


Fig. 288



Fig. 289



Fig. 290



Fig. 291





Fig. 292



Fig. 293



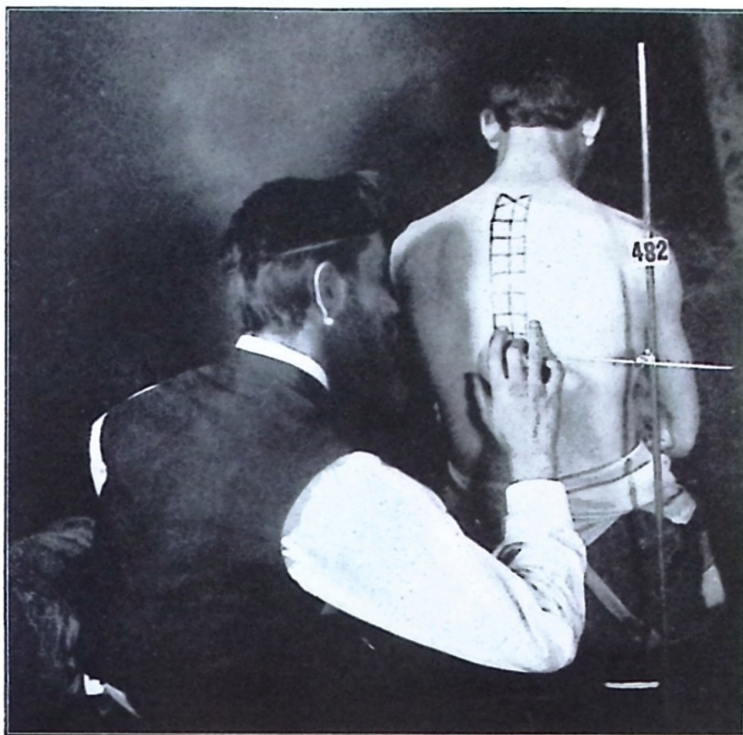


Fig. 294



Fig. 295



Fig. 296



Fig. 297

Fig. 287. This set of views is to show how to palpate for transverse processes and then how to compare them with the spinous processes. Showing three fingers, one on each transverse and third, or center one, on spinous process. Normal.

Fig. 288. *Superior* transverse process subluxation. Notice position of fingers are *above* the vertebra in question.

Fig. 289. Both transverse and spinous processes are *inferior* of the lines in question to where it should be.

Fig. 290. *Right* subluxation. Left transverse process inferior. Right transverse superior.

Fig. 291. *Left* subluxation. Left transverse process superior. Right transverse inferior.

Fig. 292. *Right* subluxation. Both transverse processes to the right of their normal positions as is indicated by comparison with normal lines.

Fig. 293. *Left* subluxation. The opposite of Fig. 292.

Fig. 294. *Right superior* subluxation. Left transverse left inferior. Right transverse right superior.

Fig. 295. *Left superior* subluxation. Left transverse left and superior. Right transverse to the left and inferior.

Fig. 296. *Left inferior* subluxation. Left transverse left and inferior. Right transverse also left and inferior but more so than the left transverse.

Fig. 297. *Right inferior* subluxation. Left transverse inferior and to right as is also the right altho the left is more so.

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The eighth dorsal spine corresponds to the lower level of the heart and to the central tendon of the diaphragm.

### 3. *Normal position and articulations.*

Whenever adjustment is justified to be given upon transverse process in preference to the neuropophyses, remember that each projection is but a portion of the whole, therefore when one division is adjusted the balance moves with it proportionately, according to distance, anterior, posterior or laterally from the median line. It is but a question of convenience, ease, adaptability or leverage that determines whether you shall use one in preference to the other.



The person expert in his work will most usually prefer that which is more easily forced and more definitely decided about and acted upon—the spinous process. The expenditure of power is the same upon posterior left or right transverse as upon a right or left spinous process and the risk of damage increased.

5. *Relative position of adjacent vertebrae.*
6. *Where nerves are impinged.*

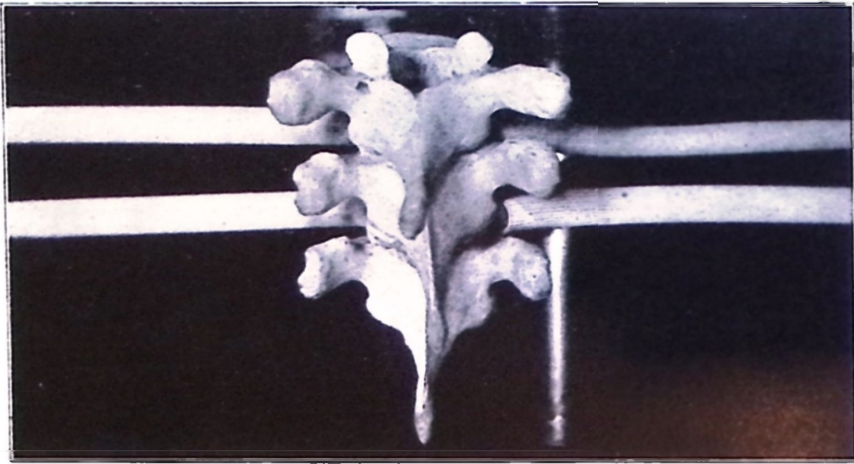


Fig. 298. Showing four normal nerves emitting from between the vertebrae.

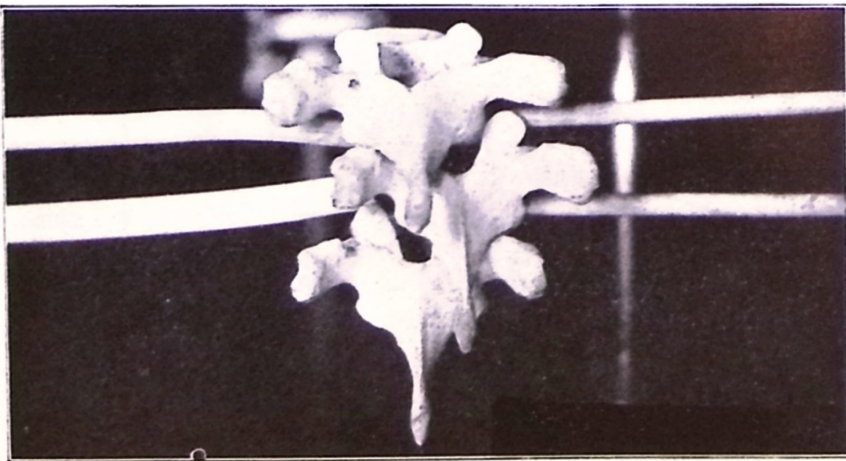


Fig. 299. *Left* subluxation showing pressure on left superior and left inferior.

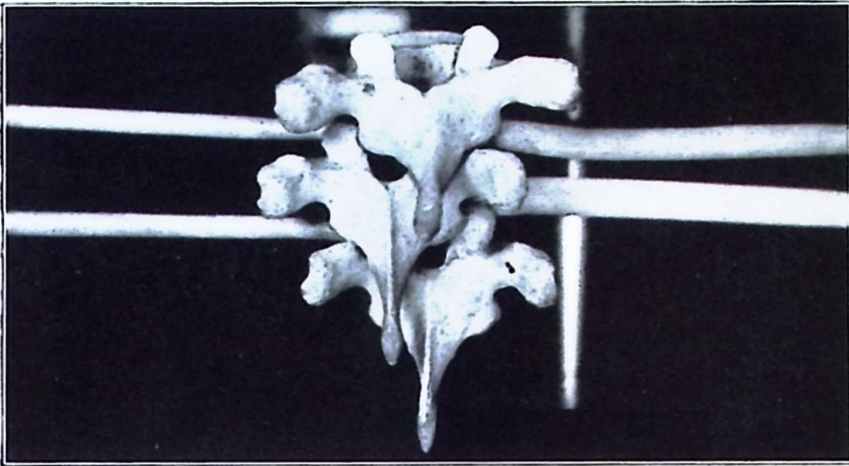


Fig. 300

Fig. 300. *Right* subluxation showing pressure on right inferior.

Fig. 301. *Superior* subluxation showing pressures on left superior and right superior.

Fig. 302. *Inferior* subluxation showing pressures on left inferior and right inferior.

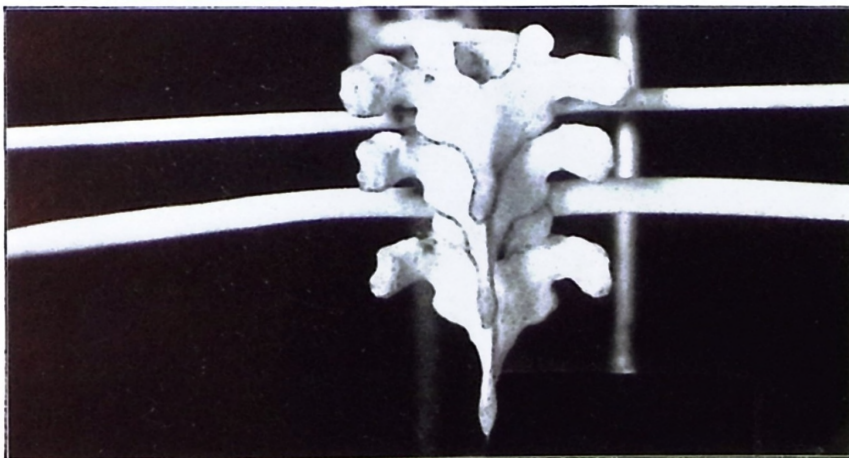


Fig. 301

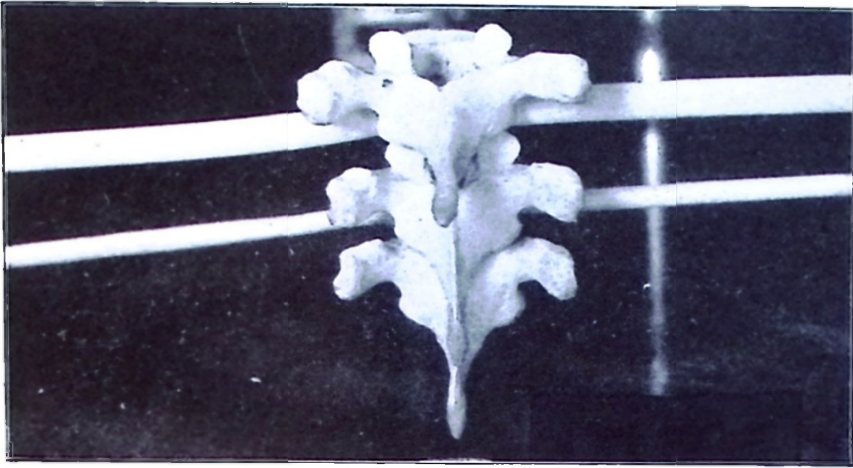


Fig. 302

Fig. 303. *Left superior* subluxation showing pressure on left superior.

Fig. 304. *Left inferior* subluxation showing pressure on left inferior.

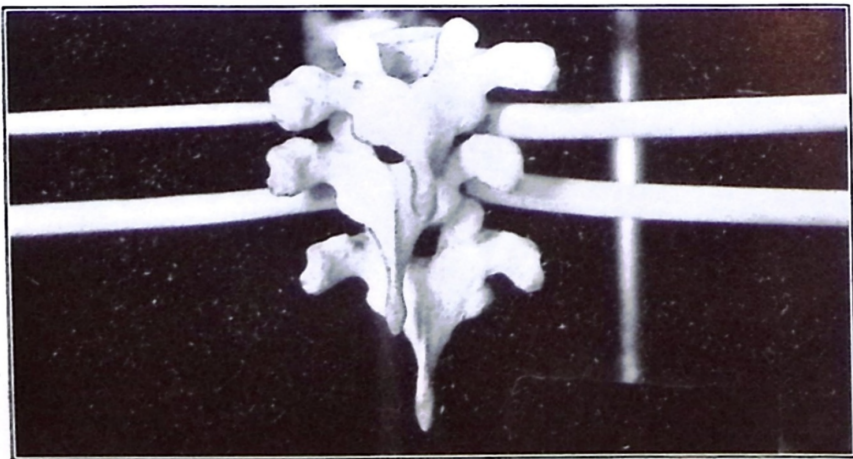


Fig. 303



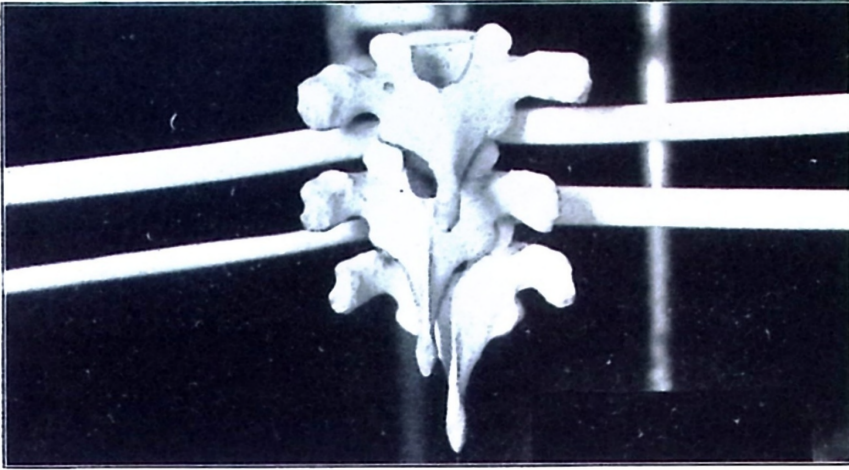


Fig. 304

Fig. 305. *Right superior* subluxation showing pressure on right superior.

Fig. 306. *Right inferior* subluxation showing pressure on right inferior.

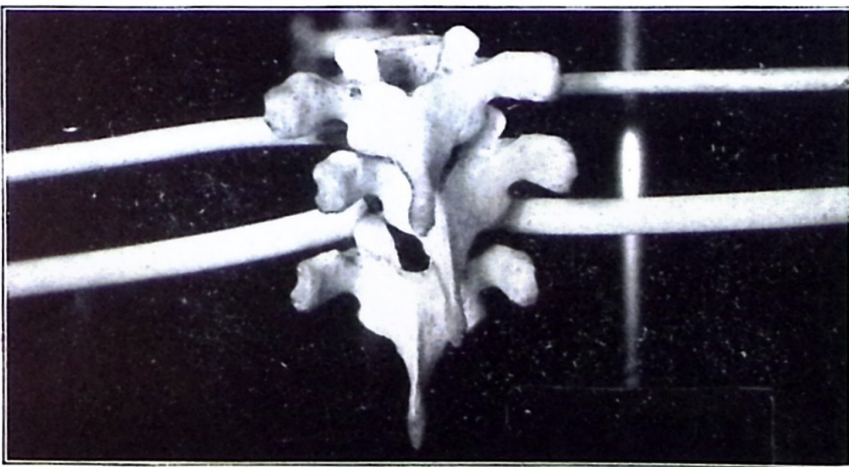


Fig. 305

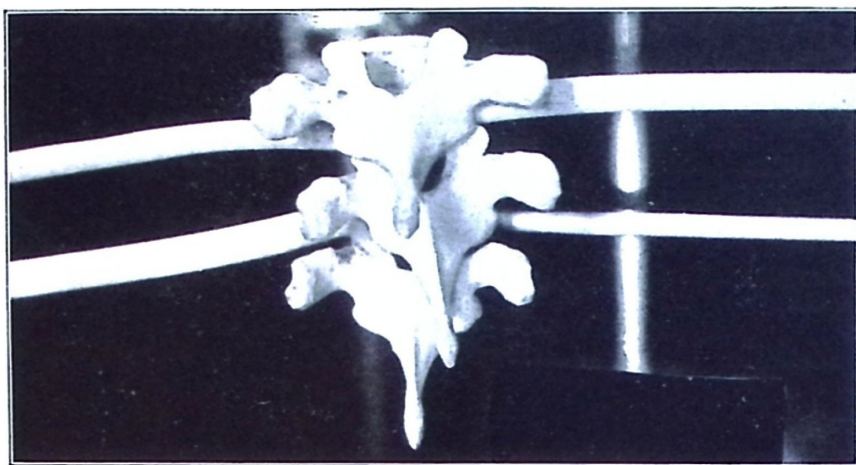


Fig. 306

Fig. 307. *Posterior* subluxation showing pressure on right superior and inferior.

Fig. 308. *Posterior* superior subluxation showing pressure on superior.

Fig. 309. *Posterior* inferior subluxation showing pressure on right inferior.

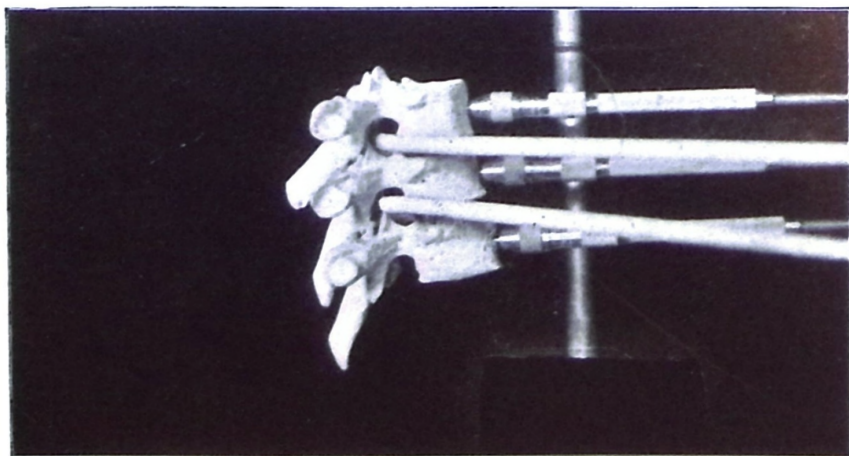


Fig. 307

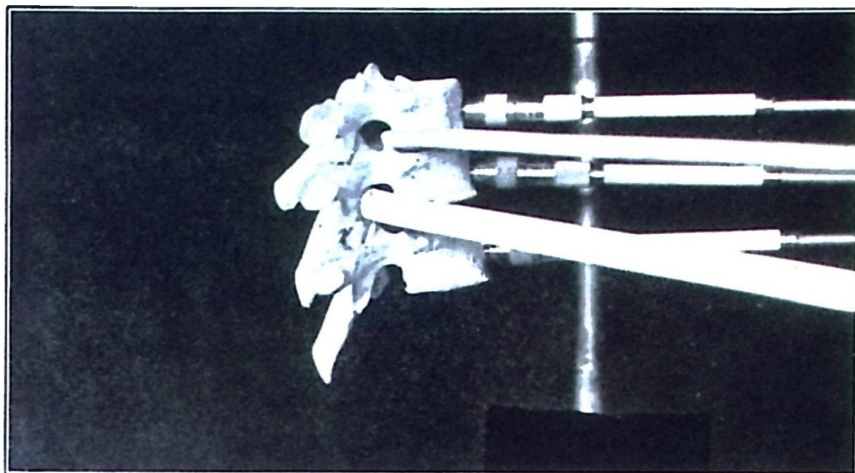


Fig. 308

7. *How and what makes pressures.*

8. *Functions and organs involved. Location of—*

Upon the left would issue those nerves which ultimately reach the spleen. Upon the right, nerves issue to such organs as would be found upon a transverse section diversifying slightly above and below. Lower part of liver; lower lungs and upper part of diaphragm and perhaps a part of the stomach, although low.

9. *Adjustments necessary to correct each.*

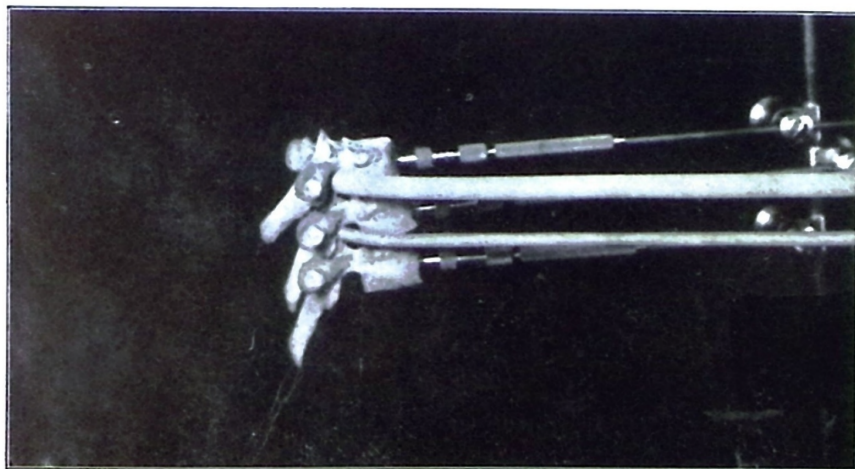


Fig. 309



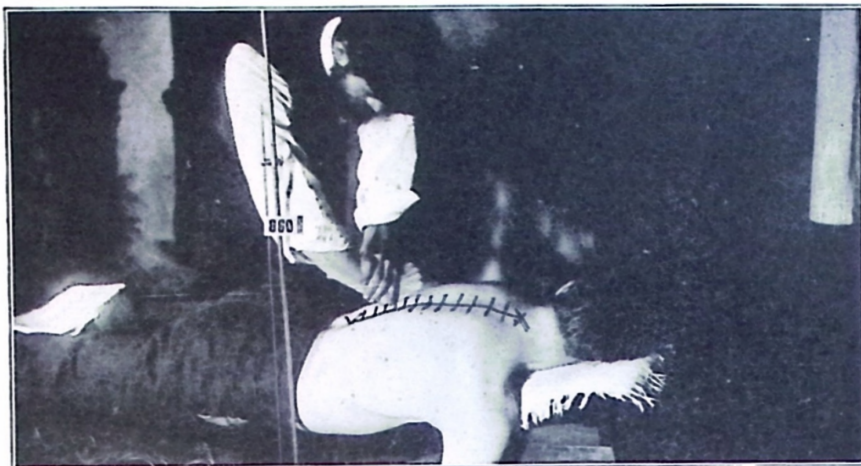


Fig. 310



Fig. 311



Fig. 312



Fig. 313



Fig. 314

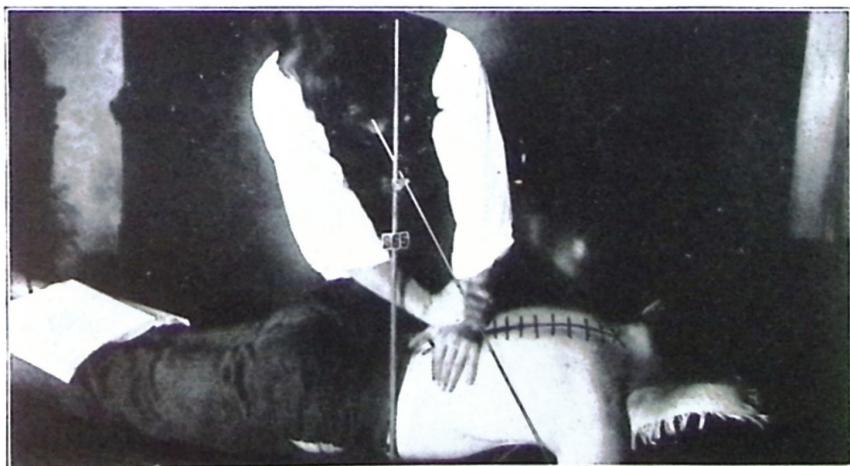


Fig. 315



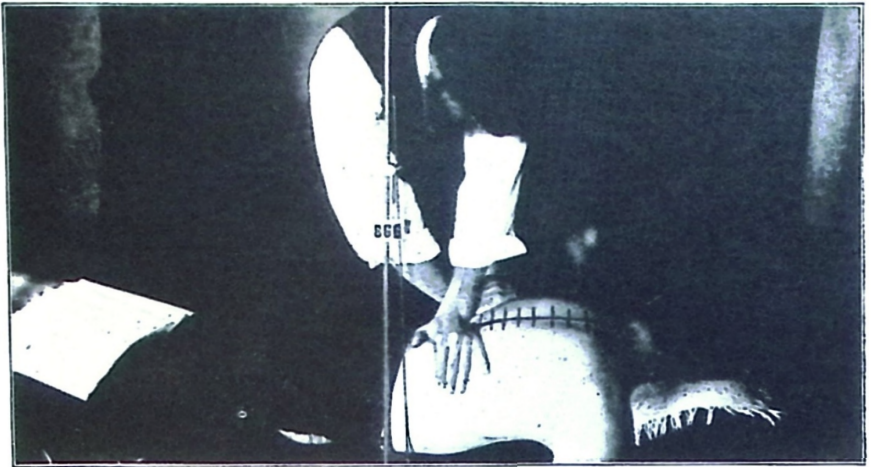


Fig. 316

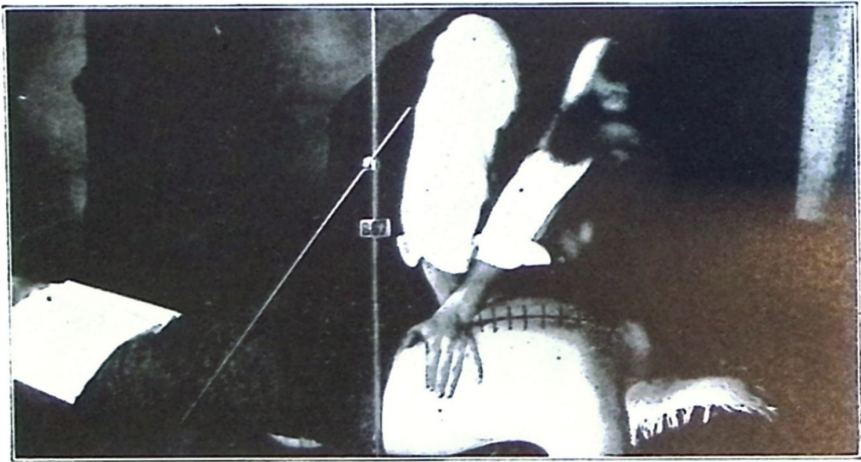


Fig.317



Fig. 318





Fig. 319



Fig. 320



Fig. 321

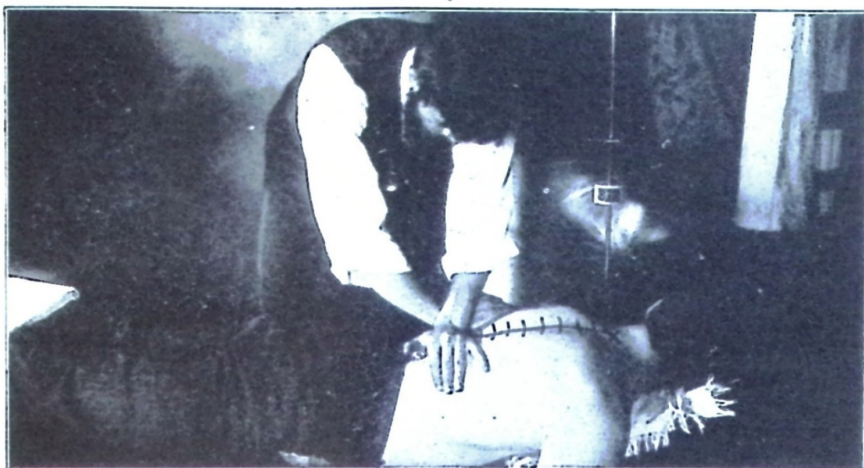


Fig. 322



Fig. 323



Fig. 324





Fig. 325



Fig. 326



Fig. 327



Fig. 310. Transverse adjustment. Heel of right hand on left transverse. Posterior adjustment. The direction is anterior.

Fig. 311. *Posterior superior* subluxation of 8th dorsal. Transverse adjustment. Heel of right hand on left transverse. Direction is inferior.

Fig. 312. *Posterior inferior* subluxation of same vertebra. Transverse adjustment. Same parts thereof but different direction.

Fig. 313. Heel of left hand on right transverse. Posterior subluxation.

Fig. 314. *Posterior superior* subluxation of 8th dorsal. Transverse adjustment. Heel of left hand on right transverse. Notice direction is anterior inferior.

Fig. 315. *Posterior inferior* subluxation of 8th dorsal. Transverse adjustment. Heel of left hand on right transverse. Direction is anterior superior.

Fig. 316. Double transverse adjustment for a *posterior* subluxation. Right hand on left transverse and left hand on right transverse.

Fig. 317. Double transverse adjustment of *posterior superior* subluxation. Hands crossed. Direction is anterior inferior.

Fig. 318. Double transverse adjustment of *posterior inferior* subluxation. Hands crossed. Direction is anterior superior.

Fig. 319. Double transverse adjustment, hands crossed. Left transverse inferior and right transverse superior.

Fig. 320. Double transverse adjustment, hands crossed. Right transverse inferior and left transverse superior.

Fig. 321. Double transverse adjustment of *right* subluxation. Both hands are to the right of where they should be in normal.

Fig. 322. Double transverse adjustment of *left* subluxation. Hands to left of where they should be in normal.

Fig. 323. Heel of left hand on left transverse and heel of right hand on right transverse. Hands locked. *Posterior* subluxation.

Fig. 324. Heel to left hand on left transverse, heel of

right hand on right transverse. Hands locked. *Posterior superior* subluxation.

Fig. 325. Heel of left hand on left transverse, heel of right hand on right transverse. Hands locked. *Posterior inferior* subluxation.

Fig. 326. Heel of *left* hand on left transverse, heel of *right* hand on right transverse. Hands locked. Left transverse superior, right transverse inferior. The hands working in *contrary* directions.

Fig. 327. Heel of *left* hand on left transverse, heel of *right* hand on right transverse. Hands locked. Right transverse superior, left transverse inferior. The hands working in *contrary* directions.

---

In the upper dorsal the transverse processes are slightly above the level of the spinous processes; as the latter proportionately becomes longer it slants more obliquely, therefore would be on a lower level. The transverse adjustment, is given in one of these ways, viz: laterally, superior, or inferior, posterior or anterior.

This adjustment is only used in those cases where the disease is confined strictly to one side and the object utilized is to lower that side to release pressures upon those nerves. Good examples are heart trouble, or pleurisy, etc., of one lung; pains in a localized zone of the thoracic or pelvic cavities, or lower limbs. This movement is more effective in the upper dorsal and lower three lumbar. It is almost impossible in cervical with the exception of Atlas. If the pressure be upon the superior foramina of an inferior posterior subluxation of vertebra then the direction would be superior on right or left transverse according to which side the distress was upon. If a certain spinous process is much out of line, the object should be to adjust that first. If greater leverage is wanted, resorting to the transverse process if the former does not move. In adjusting superior the same positions of hands are used viz: the heel, in getting inferiorly to the process and making the movement forward and superior. If it is superior and is wanted vice-versa, reverse the position, placing the hand above the process.

#### 10. *How to give adjustments correctly.*

I prefer the use of the spinous process and if properly

understood and knowingly used, as good or better results can be obtained with it.

This adjustment can be very aptly used where torsion exists in many forms of curvatures. Oftentimes in scoliosis and rotatory conditions the transverse will be as much or more prominent than the spinous is in normal conditions.

Where it is desirous or advantageous to use the transverse, bear in mind the same basic principles as would be utilized with the spinous, with the exception that where a left movement of spinous is required an anterior or transverse gains the same end.

Fig. 310. Is normal showing the spinous process situated within the median line. The transverse processes are shown to be on a horizontal medium line.

Fig. 311. Posterior superior subluxation. The posterior is the one from which all work must be accomplished. In this illustration the right is posterior and superior therefore is to the rear of the median line, which should be at a horizontal right angle to the perpendicular median horizontal line. The adjustment would be upon either or both sides placing the transverse anterior; working upon its pivotal articulations would lower both.

Fig. 312. Posterior inferior subluxation. Would be the reverse of Fig. 311 the adjustment being given with the opposite hand on the opposite side.

The movement in either of these cases should be directly anterior.

Fig. 313. Posterior Subluxation. In this case, personally, I prefer the spinous process for the direct and specific work but if the transverse is desired it should be used with left hand on right transverse. The different ways in which the hands can be placed is almost endless, but in this instance the force should be given anterior. *The P. S. C.* has, in years past discovered, used, taught and discarded dozens of various transverse as well as other adjustments all because the spinous was in the long run the most direct, specific and simple.

Complexity is often desired by students who cannot learn the value of simplicity.



The value of complexed subjects is just so much as it mystifies the listener, for under all multiplied ideas *is a fundamental principle* which is simple to the deep, logical student. The higher the elevation a man reaches in intelligence, the more simple are his habits and actions.

Fig. 317. Posterior subluxation. The points of advice in this case are diametrical to the foregoing and can be considered in the adjustment, as in the use of both hands. The spinous process would be adjusted inferiorly or the double transverse accordingly.

Fig. 324. Posterior superior subluxation. The left transverse is here the reverse of the former, viz:—posterior and inferior, the adjustment being given in an anterior and superior direction upon that side only.

Fig. 325. Posterior inferior subluxation. According to diagram the right transverse would be posterior, the adjustment being given upon this promontory in an anterior direction; this movement would bring to normal position as opposite.

11. *What means, and portions thereof, to use.*

The heel of the hand is used in the same manner as portrayed under the adjustment of spinous processes. The left hand is the nail of the right side and vice-versa aiming not to overlap the fingers of the fixed hand over the spinous processes of the adjoining vertebrae. Palpation is the same, with 3 fingers running down just lateral to the vertebral groove. More deeply imbedded processes require more thoro palpation to discern them. Comparison by the rule of 3 is as important here as anywhere else.

12. *What diseases to adjust 8th dorsal for.*

Enlarged spleen, splenitis, calculi of the spleen, catarrh of; lack or excess of its secretions; cancer of; tumor of; etc. All of these as a general rule have the point of emergence of nerves upon the left side. Those emitting upon the right side sometimes go to throat and can be traced to that region, but usually controlling the functions of pancreas upon that side and also involve such tissues as would be in that circular section.

## CHAPTER 20.

## 9TH DORSAL.

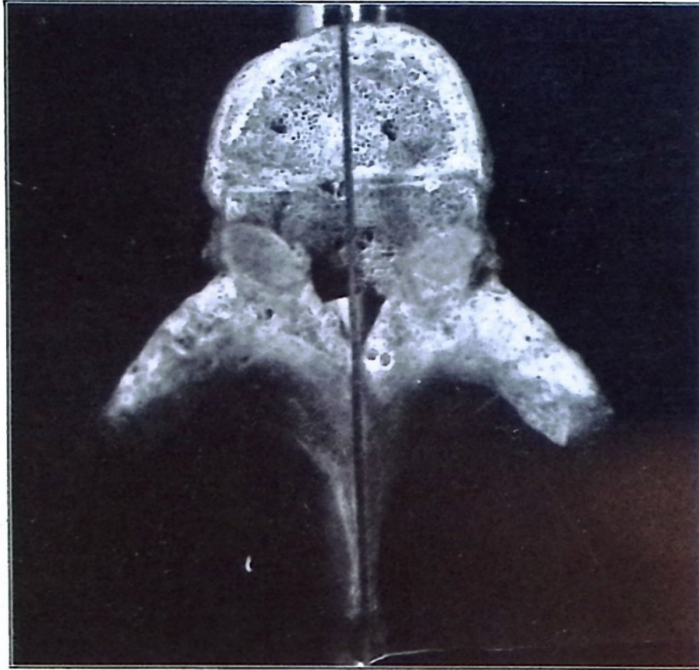


Fig. 328

1. *Vertebra and its title. Spl. P.*
2. *Superficial palpation and landmarks.*

In these regions, the dorsal and superior lumbar palpation is an easy matter especially for the neurapophyses, tho not so in fleshy persons. Ordinarily in the especially lean, the transverses show up extra work, but since they are more anterior and placed deeper, palpation is necessarily harder than of the spinous.

3. *Normal position and articulations.*

This vertebra has a costal facet on its pedicle above but is without any on its centrum below.

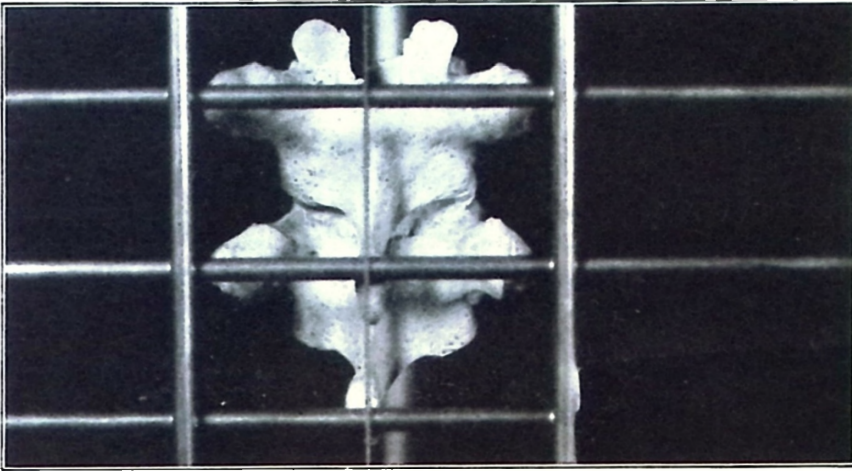


Fig. 329

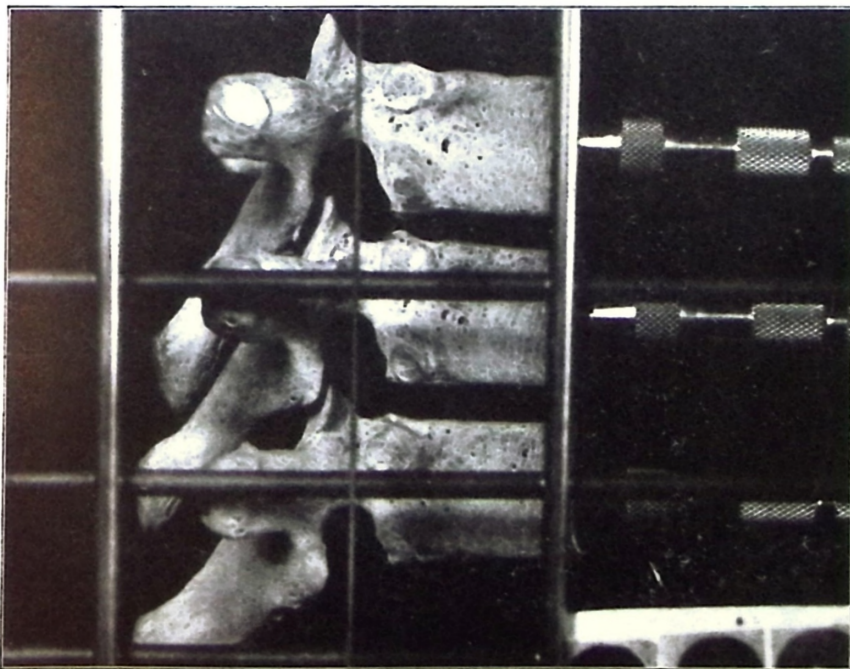


Fig. 330



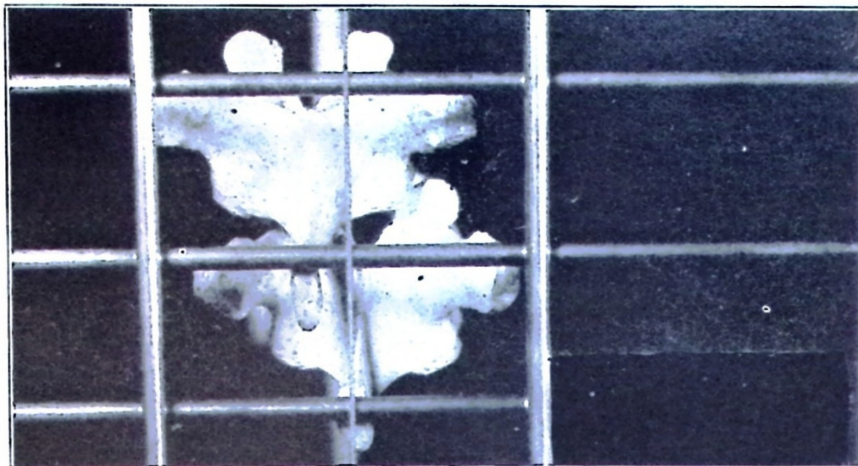
4. *Sublurations, described and illustrated.*

Fig. 331



Fig. 332

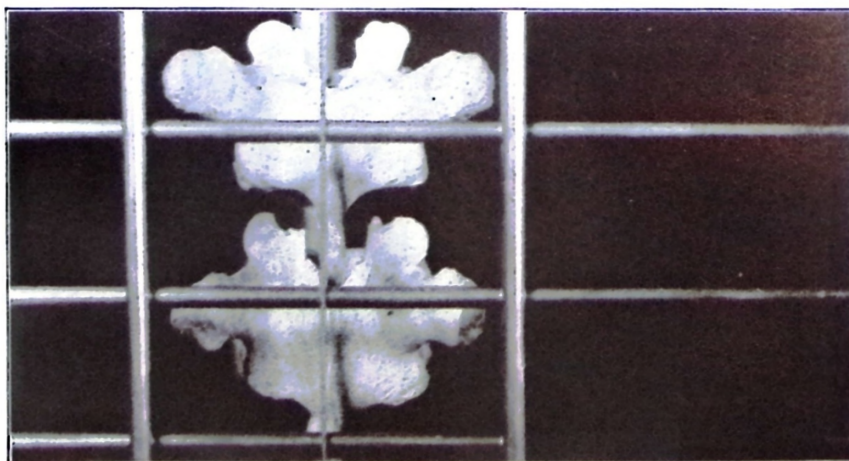


Fig. 333

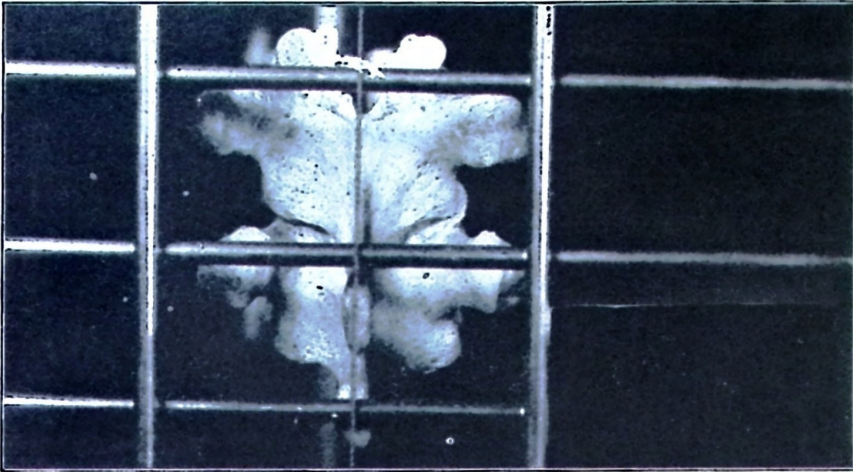


Fig. 334

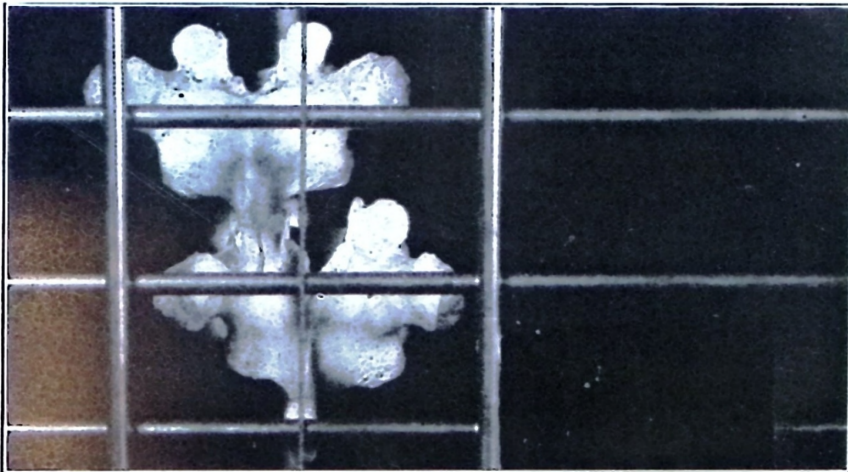


Fig. 335

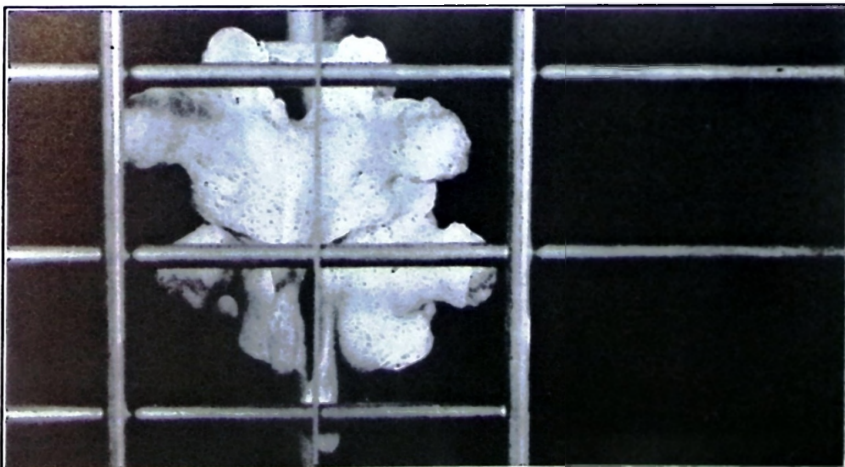


Fig. 336



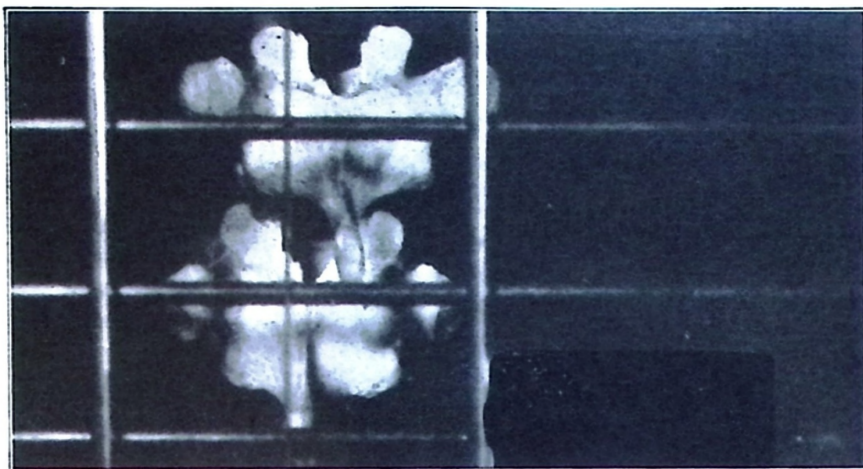


Fig. 337



Fig. 338



Fig. 339.





Fig. 340



Fig. 341

Fig. 329. *Posterior* view of 9th and 10th dorsal. The square has been made for comparison of spaces and positions.

Fig. 330. *Right lateral* of 8th, 9th and 10th dorsal.

Fig. 331. *Left* subluxation of 9th dorsal.

Fig. 332. *Right* subluxation of 9th dorsal. *Posterior* view.

Fig. 333. *Superior* subluxation of 9th dorsal. *Posterior* view.

Fig. 334. *Inferior* subluxation of 9th dorsal. *Posterior* view.

Fig. 335. *Left superior* subluxation of 9th dorsal. Posterior view.

Fig. 336. *Left inferior* subluxation of 9th dorsal. Posterior view.

Fig. 337. *Right superior* subluxation of 9th dorsal. Posterior view.

Fig. 338. *Right inferior* subluxation of 9th dorsal. Posterior view.

Fig. 339. *Posterior* subluxation of 9th dorsal. Left lateral view.

Fig. 340. *Posterior superior* of 9th dorsal. Left lateral view.

Fig. 341. *Posterior inferior* subluxation of 9th dorsal. Left lateral view.

5. *Relative position of adjacent vertebrae.*

6. *Where nerves are impinged.*

7. *How and what makes pressures.*

8. *Functions and organs involved. Location of—*

The functions would be such as are of those organs in this zone, remembering that each of the viscera has its distinct general function such as no other possesses. It will be this, in combination with more or less of the usual 7, that will be excessive or lacking that will be noticeable. The combinations of these would be endless altho the location of the cause is specific and direct.

9. *Adjustments necessary to correct each.*

10. *How to give adjustments correctly.*

11. *What means, and portions thereof, to use.*

12. *What diseases to adjust the 9th dorsal for.*

The diseases that could or would be named pending an investigation of these functions that are abnormal would be endless and need a name to fit the perception of the person trying to tell what they were. At best, naming of a disease is a guess work policy but the locating of the cause of the abnormal functions for a specific area would be as direct as exact. On the right the superior part of the diaphragm would be reached. For affections of the spleen adjust to left unless subluxations prove to the contrary.

CHAPTER 21.  
10TH DORSAL.



Fig. 342.

1. *Vertebra and its title. Lower Spl. P. or Sup. K. P.*
2. *Superficial palpation and landmarks.*

Taking the left hand upon the right side, dropping the thumb under right 12th rib and then letting the little finger touch on the spine obliquely toward left shoulder will approximate the spinous process of this vertebra. The tenth dorsal spine corresponds to the lower borders of the lungs, which when fully expanded follow the upper borders of the eleventh rib.

3. *Normal positions and articulations.*

This vertebra has a single facet on its upper border and a small one on the upper surface of the transverse process.



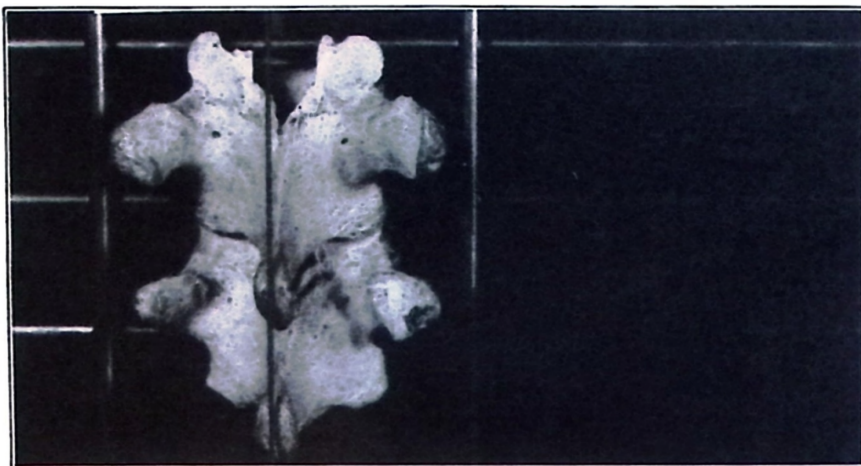


Fig. 343. *Posterior* view of 10th and 11th dorsal. Vertebrae behind rods.

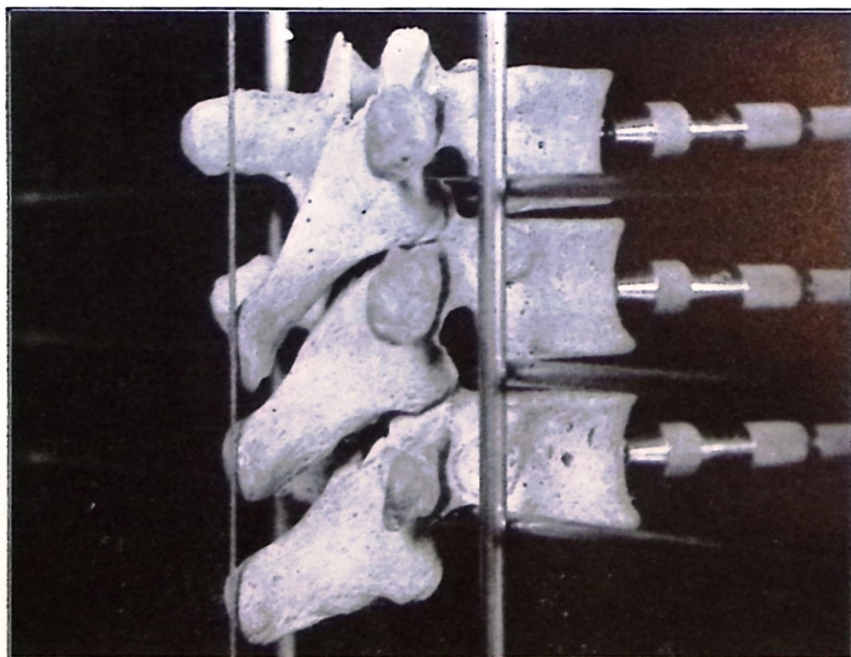


Fig. 344. *Right lateral* view of 9th, 10th and 11th dorsal.

4. *Subluxations, described and illustrated.*

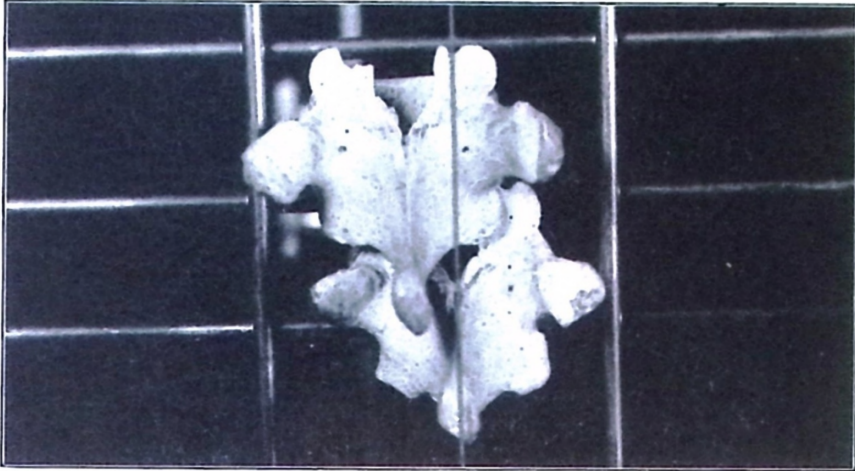


Fig. 345. *Left* subluxation of 10th dorsal.

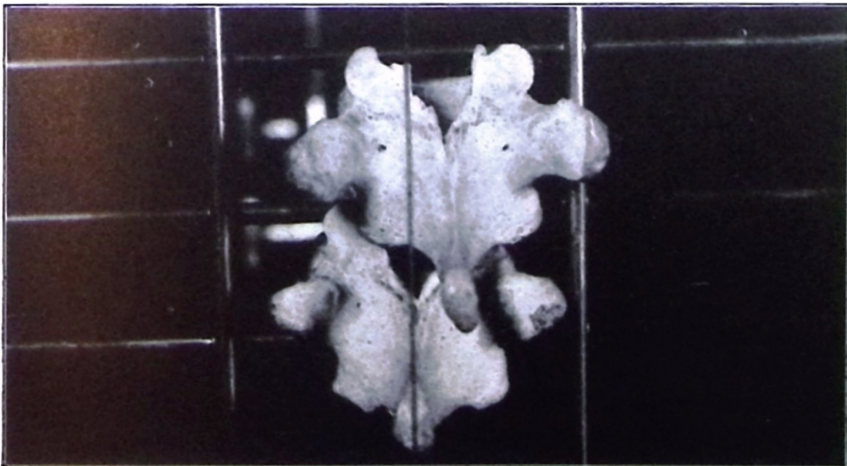


Fig. 346. *Right* subluxation of 10th dorsal.

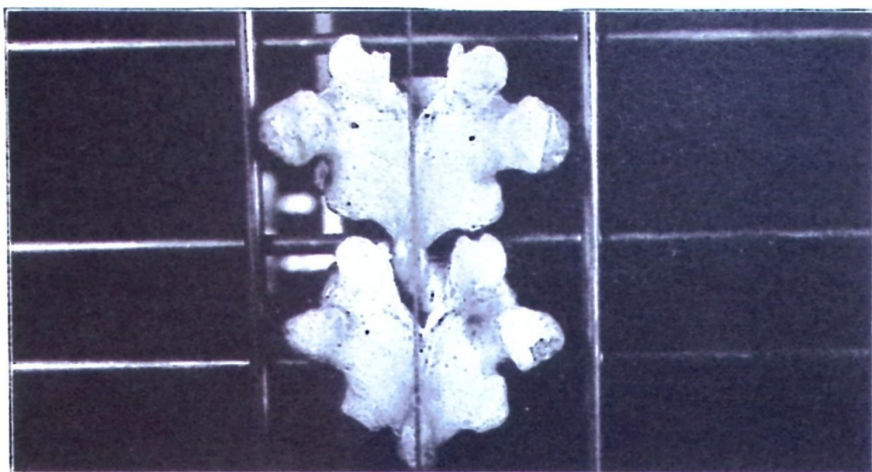


Fig. 347. *Superior* subluxation of 10th dorsal.

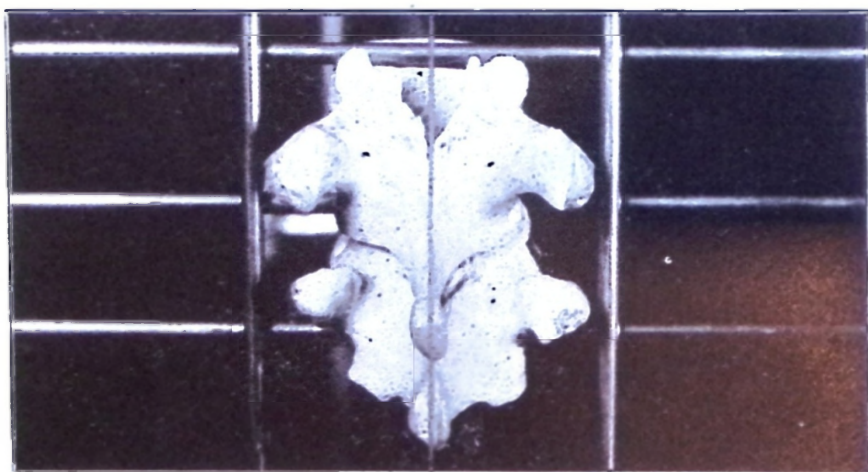


Fig. 348. *Inferior* subluxation of 10th dorsal.

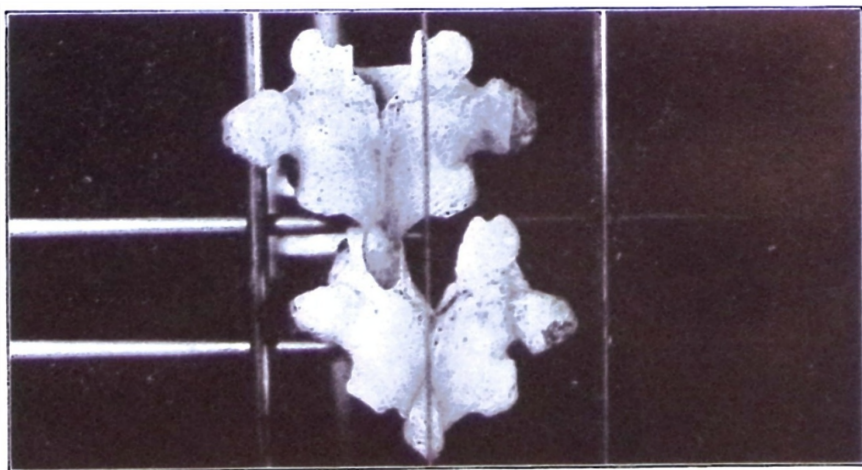


Fig. 349. *Left superior* subluxation of 10th dorsal.



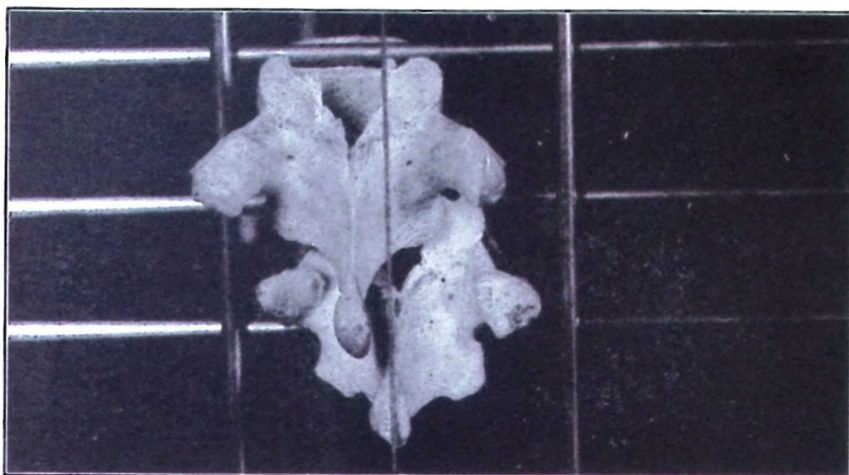


Fig. 350. *Left inferior subluxation of 10th dorsal.*

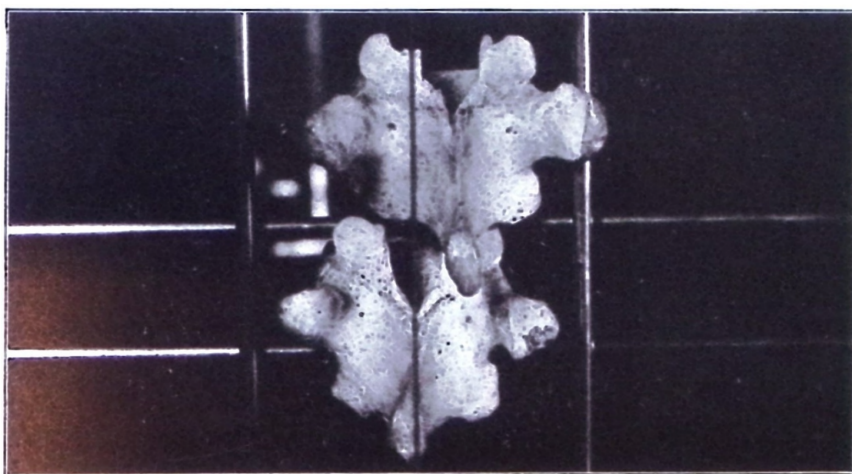


Fig. 351. *Right superior subluxation of 10th dorsal.*

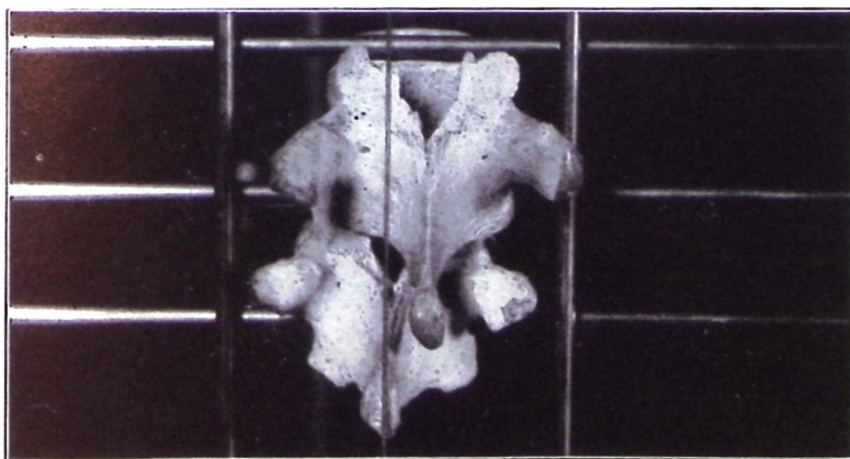


Fig. 352. *Right inferior subluxation of 10th dorsal.*



Fig. 353. *Posterior subluxation of 10th dorsal.*



Fig. 354. *Posterior superior subluxation of 10th dorsal.*



Fig. 355. *Posterior inferior subluxation of 10th dorsal.*



5. *Relative positions of adjacent vertebrae.*
6. *Where nerves are impinged.*
7. *How and what makes pressures.*
8. *Functions and organs involved. Location of—*

Many lame backs in the superior region of the small of the back have their origin at 10-11 or 12th dorsal, oftentimes finding one or a series of these. When such is the case use the same principles as for curvatures, as it is, in fact the original physical representative of a cause and would eventually become greater.

9. *Adjustments necessary to correct each.*

The general trend of adjustments for a local or general curvature regardless of character is to return it to the median lines both perpendicularly and horizontally according to the normal curves. If it be a left scoliosis the *general* direction of all adjustments should be to the right altho special symptoms, such as pain on left side might locally dictate otherwise, temporarily, but permanently the correction would be as aforesaid.

In a kyphosis the adjustment is to anterior to reach the normal primary and secondary curves. In all lordoses a kyphosis precedes it and the former acts more as an adaptation.

In analysis of such cases use particular caution to differentiate between the curvature and its adapting curves for adjustment for all cyphosis always will in proportion as they are lowered the lordses will resume their normal. The correcting of the spine to median line is to but return all other abnormalities that have worried thousands.

In every curve there are three adjusting points, the most posterior point or where greatest concussion of forces took place and the superior and inferior starting and ending terminals. You must, at discretion, modify the adjustment to include vertebrae above and below these, in order to return all to normal shape. While it is not within the province of this text to detail ankyloses, yet it is sufficient to state that continued and correctly applied Chiropractic adjustments will restore normal configuration and freedom. The exostoses were placed around subluxated vertebrae to keep them from getting worse or to lock them into abnormal position for fear the caries etc.,



etc., might produce further subluxation and consequently death. When Innate Intelligence's senses are aware that such is no longer needed because vertebrae are being replaced, it will be removed.

It is now a well established fact that in proportion as vertebrae resume their normal position just that much is the exostoses converted to liquid chemicals and utilized at distant parts of the body. Hence as progress is pursued the work becomes easier and results faster and more apparent.

10. *How to give adjustments correctly.*

11. *What means, and portions, thereof to use.*

12. *What diseases to adjust the 10th dorsal for.*

K. P. is one of the most important local regions in the spine. The junction of the 12th dorsal and 1st lumbar is the weakest in the spine. The dorsal has the added strength of the costales and the lumbar their increased dimensions and added thickness. To obviate this, Innate has supplied the junction with a posterior articular lock. An extension of the accessory and mammillary tubercles which project superiorly over-lapping the inferior facets of the superior vertebra. This articular lock may be shifted in position, varying one or two above or likewise below the 12th dorsal altho it is usually between the 12th dorsal and 1st lumbar. Early and frequent subluxation in youth do, in a large majority, prevent the lock from forming, hence a constant permanent ever increasing weakness at this origin.

Consequently the point of exit of those nerves leading to and conveying mental impulse from brain to kidneys are almost always involved. Only in one case have I had the pleasure of finding K. P. normal.

I have enjoyed the unique distinction of examining Sandow's spine. It was normal with the exception of K. P. He persistently refused to acknowledge my repeated assertions that his back was lame at that place. He admitted this fault ("in the most perfect man living") and described a lame back at that juncture and also a slight kidney trouble.

The nerves from that locality go to and make manifest the functions of kidneys which are the excreting organs

for all that liquid waste that gathers in the system. It is thus a very important and prominent locality to the Chiropractor.

As is usual in all diseases wherein Serous Circulation (See *The Science of Chiropractic*, Vol. 2,) and the functions of the kidneys are involved, either might be in excess of a diminution of its performance, consequently too much liquid waste can gather or be excreted, the former creating all the conditions of dropsy, serodaema etc., etc. The latter creating the opposite or the dry, scaly or eruptive conditions. With these unlimited conditions, which are found at one of the combinations that exist with so many general fevers and other diseases, eruptive or otherwise, it can be plainly seen that Serous Circulation is an important subject and K. P. the controller of its excretions are organs not to be overlooked.

The so-called contagious or infectious diseases have their basis worked around the abnormal condition of the general system as regards to these organs primarily. If the right abnormal conditions exist in this circulation, rest assured certain eruptive conditions, varying in degrees, will stand forth.

In as much as only one of a multitude have no subluxations at this point it can be readily seen why the question of epidemics. The disease in practical measures exists in subdued form but add the external irritant and the internal body aims to respond and musters strength for the purpose but a previous weakened condition makes the resistance below normal, hence abnormal action becomes more manifest in those individuals than were previously in a condition susceptible, due to subluxations.

*CHAPTER 22.*

## 11TH AND 12TH DORSAL.

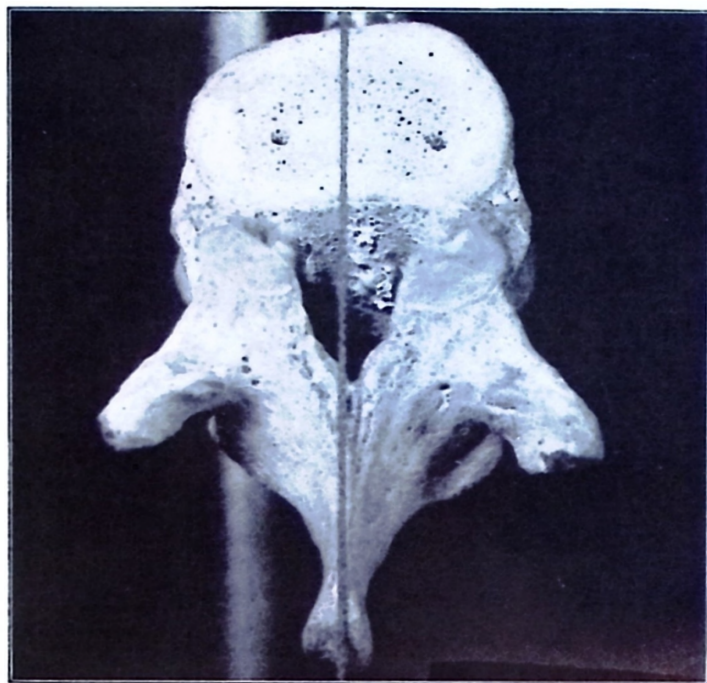


Fig. 356. 11th dorsal.

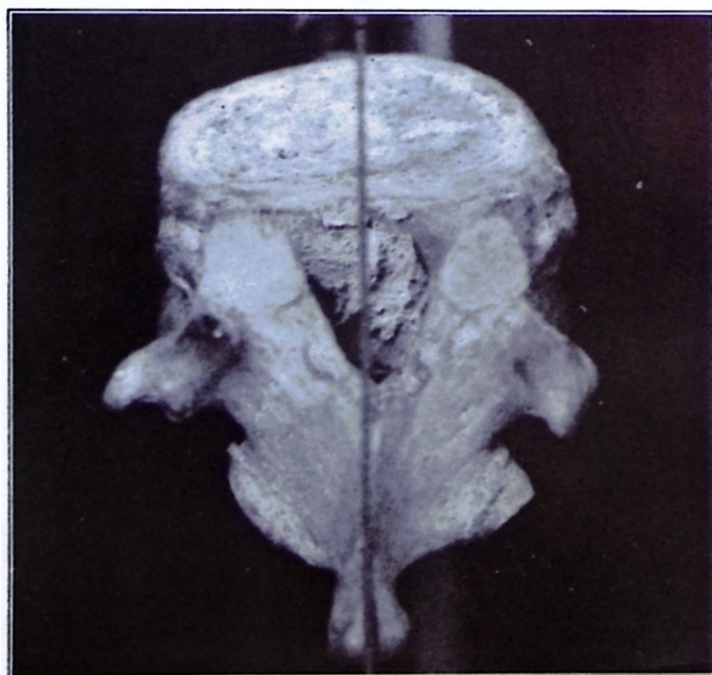


Fig. 357. 12th dorsal.



1. *Vertebra and its title. K. P.*

K. P. proper. The importance of this organic system is so great that it is proportionately more supplied than any other system, except the generative organs which is evidenced by the location of the dorso-lumbar enlargement where the nerves branch from the spinal cord on their way to the various viscera.

2. *Superficial palpation and landmarks.*



Fig. 358. Three fingers in normal for palpating when prone.



Fig. 359. Three fingers in normal. Upright position. 11th and 12th dorsal.



Fig. 360. *Posterior spinous process*—determined by palpation. Notice third or center finger.



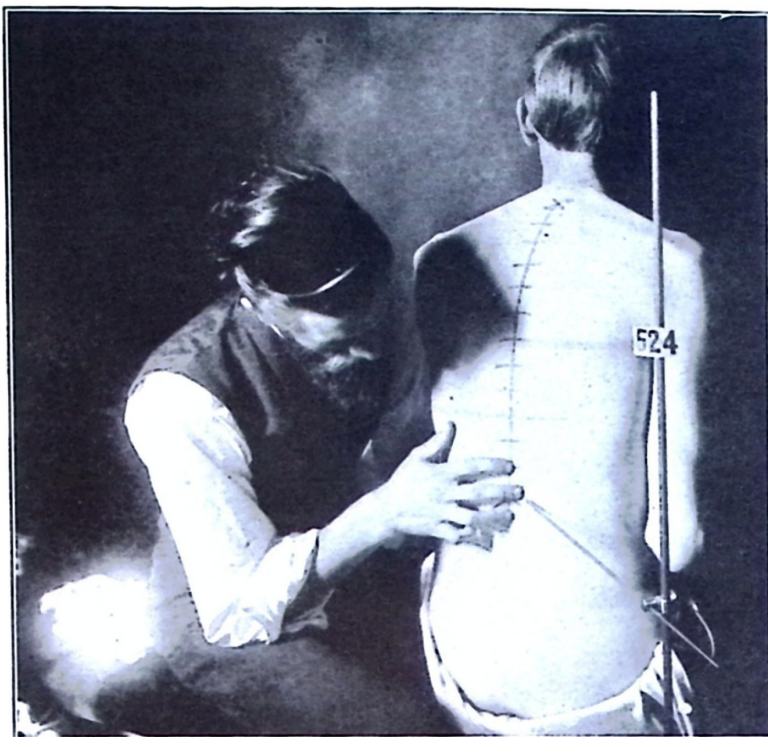


Fig. 361. *Superior spinous process.* Notice proximity of superior two fingers.

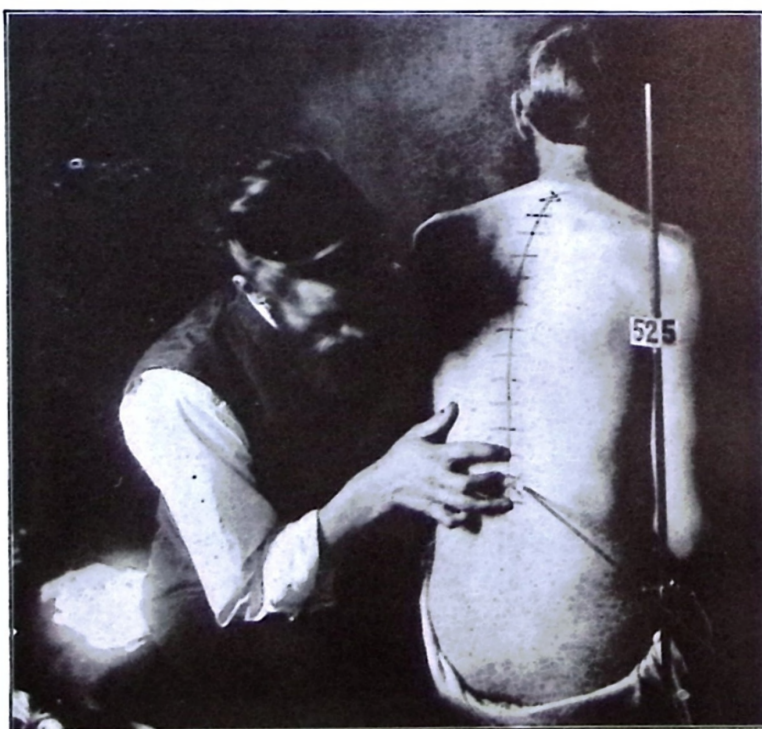


Fig. 362. *Inferior spinous process.* The opposite of Fig. 361.

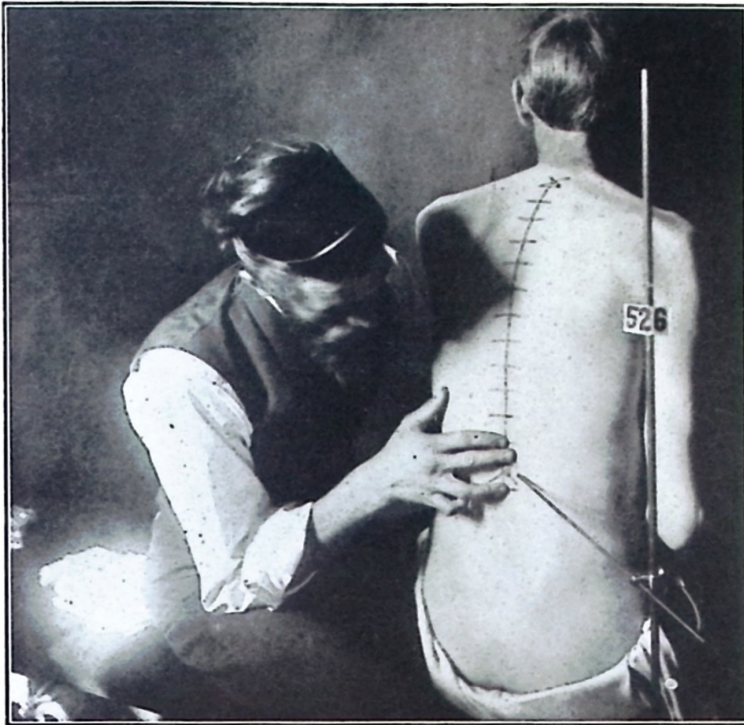




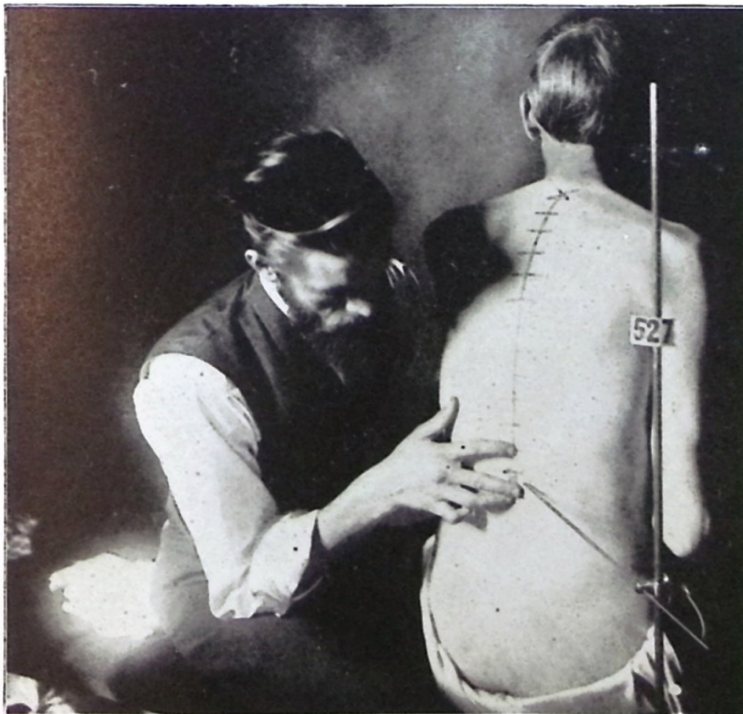
**Fig. 363.** *Right* subluxation. Palpation shows finger in that direction.



**Fig. 364.** *Left* subluxation. Palpation shows finger on subluxated spinous process to the left of median line.



**Fig. 365.** *Right superior* subluxation as determined by palpation in which the photograph shows their location.



**Fig. 366.** *Right inferior* subluxation. Notice and study the position of fingers in comparison with previous subluxations and you will grasp the import of each.



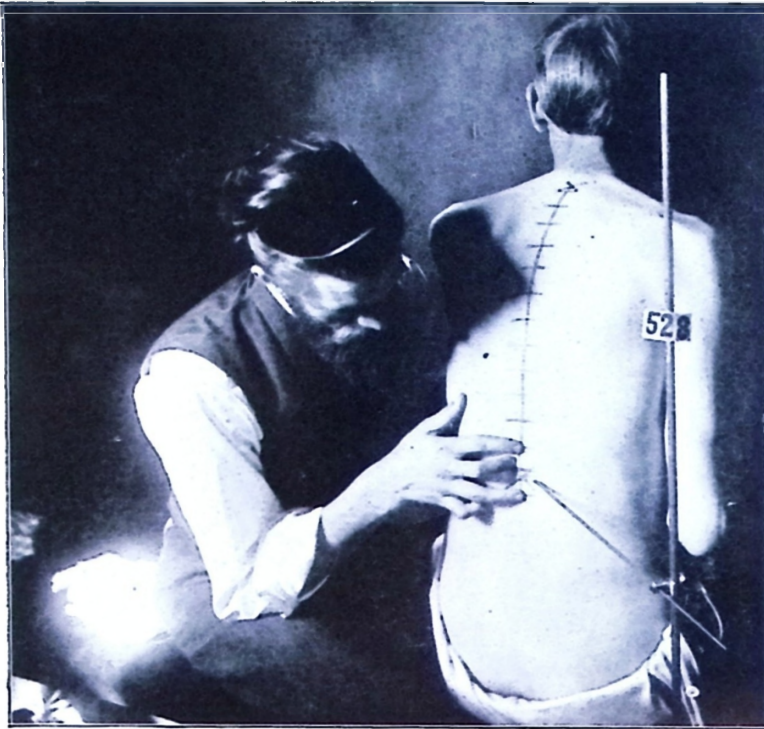


Fig. 367. *Left superior subluxation.*



Fig. 368. *Left inferior subluxation.*



The eleventh has a facet on the pedicle only for the articulation of the 11th rib.

The twelfth has a facet near the lower border of its pedicle, and the inferior articular processes are shorter and bifid, ending in the superior, inferior and external tubercles.

The latter have facets or demi-facets on the sides of their centra for the articulations of the heads of the ribs, and the lumbar vertebrae are without either a foremen or a facet. These peculiarities are most conspicuous in the middle vertebrae of each region, while at the junction of the contiguous regions the adjoining vertebrae approximate one another in conformation. This is nicely illustrated with the inferior surface of the 12th which partakes of the characteristics of the superior of the lumbar and vice-versa. This is also noticed between Occiput and Atlas; Atlas and Axis; Axis and third cervical; 7th cervical and 1st dorsal; 12th dorsal and 1st lumbar; 5th lumbar with 1st sacral; last sacral with 1st coccygeal vertebra.

3. *Normal positions and articulations.*
4. *Subluxations, described and illustrated.*
5. *Relative positions of adjacent vertebrae.*
6. *Where nerves are impinged.*
7. *How and what makes pressures.*
8. *Functions and organs involved. Location of—*

While primarily the kidneys will be affected as a result of local subluxations, the evil that occurs thereby does not alone remain confined to them. If the kidneys be paralyzed, lack of motion, and inability to gather urea will be the result, consequently this excess or what is superfluous liquid gathers generally or in these tissues locally defined which makes of it a sub-dumping ground and almost endless will be the symptoms that follow one specific subluxation of this region.

On the reverse if the pressure be light; stimulating in character; the sapping functions are excessive; the body partakes of the opposite symptoms, viz:—becomes dry; skin is scaly; dandruff; bald heads; dry hair; lack of glandular secretions; etc., etc., follow. In the former, too much secretion is formed and chemical proportions are weakened. In the latter too much concentrated, all because of one set of organs not able to be co-ordinated, dry skin be prominent and excessive heat is added as an additional local symptom here or there, we can easily have any *one* of the many eruptive diseases.

10. *How to give adjustments correctly.*

11. *What means, and portions, thereof to use.*

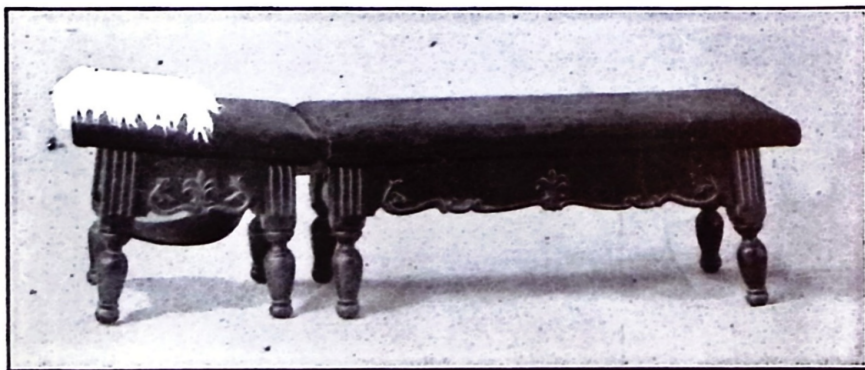


Fig. 369. The table that has been in vogue for many years in Chiropractic work and is known as "the Chiropractor's workbench".

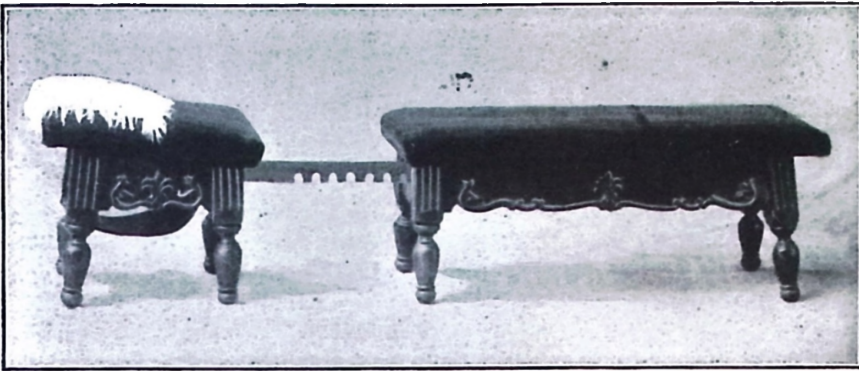


Fig. 370. The same "bench" as shown in Fig. 369 with the front division separated. The degree of space between depends upon whether adjusting high or low and can be increased at will. This table will be replaced with a more practical one in the immediate future as *The P. S. C.* is originating a table that eradicates the straining and misplacing of vertebrae that occur when the patient is lying down or getting up, before or after the adjustment.

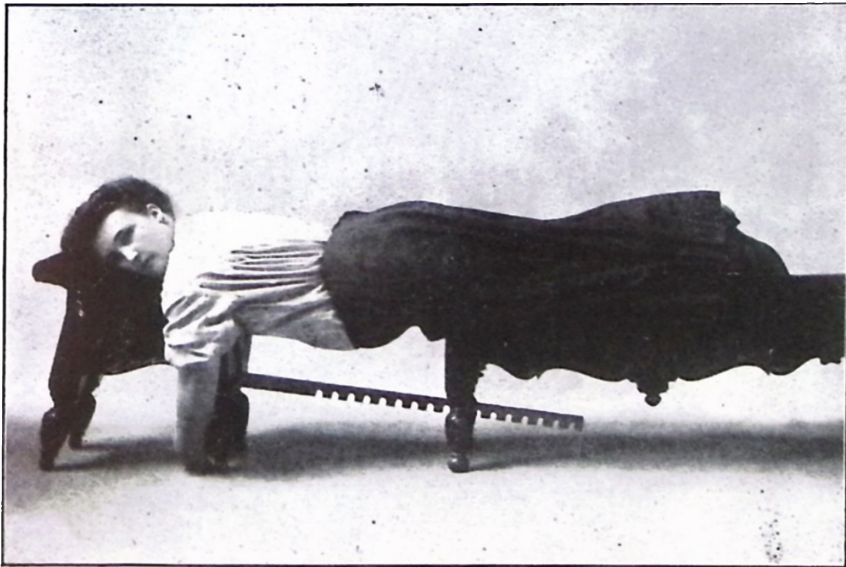


Fig. 371. Shows the position assumed by the patient when ready on the "workbench", for an adjustment. The garb worn exposes only the back. Complete relaxation, upon the part of the patient, is desired. Relaxation of the arms and muscles of the abdomen as well as back are an essential feature in making this work easy and practical.



12. *What diseases to adjust the 11th and 12 dorsal for.*

It can be observed that the names of the diseases could be listed for pages. We will allow the student to draw individual conclusions according to the outlined framework listed above and the conclusions reached by this analysis. If he wishes a scientific, carefully compiled list of diseases and where to adjust for each, I refer him to *Vol. 4. Causes Localized.*

## CHAPTER 23.

## THE LUMBAR VERTEBRAE.



Fig. 372

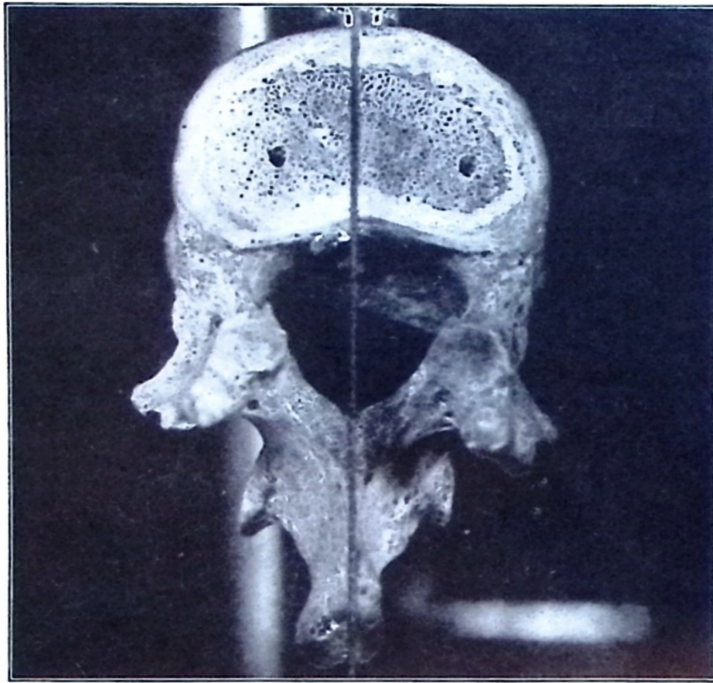


Fig. 373

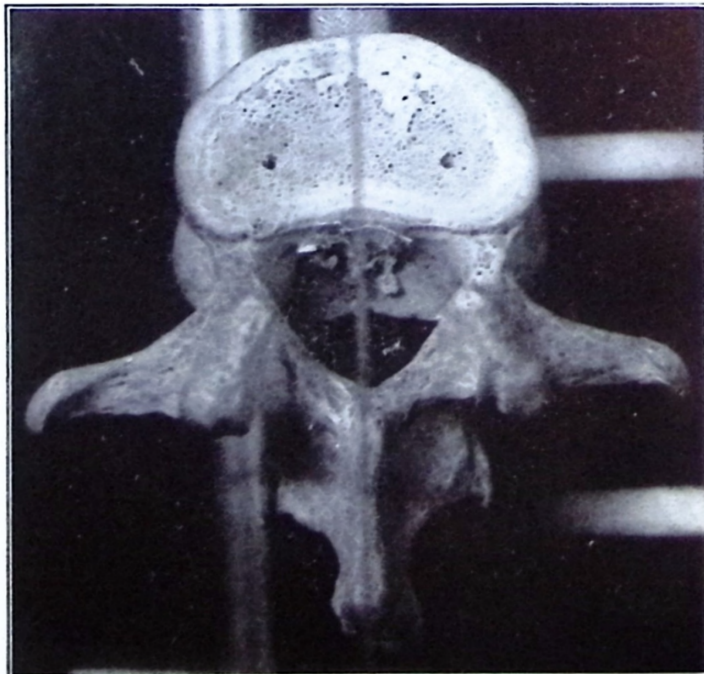
Fig. 372. *Posterior* view of the 5 lumbar vertebrae. Notice how plumb line pierces all spinous processes.

Fig. 373. *Right lateral* view of the 5 lumbar vertebrae. Notice the foramina (openings) thru which the brain nerves pass outward to the tissue cells and viscera.

*CHAPTER 23.*  
**1ST AND 2ND LUMBAR.**



**Fig. 374. 1st Lumbar.**



**Fig. 375. 2nd Lumbar.**



1. *Vertebrae and its title.* 1—2 lumbar are *U. P. P.*
2. *Superficial palpation and landmarks.*

The lumbar vertebrae are the largest segments of the vertebral column. Their bodies are more constricted in the middle and have their margins more prominent, although in other respects are like the bodies of the thoracic region. The arches are relatively less deep, there being considerable intervals between the laminae of the neighboring vertebrae upon each side. The spinal foremen is larger than in either of the upper regions, and of triangular shape. The spinous processes are broad and thick vertical projections, terminating in rough lateral tubercles below. The superior articular processes are concave and directed backward, while the inferior are convex and directed outward and forward. The transverse or costal processes are long and slender and are subject to fracture in adjusting upon them when compared to the spinous processes. They are placed in front of the articular processes instead of behind them, as in the dorsal vertebrae. The superior tuberosities point downward from the bases of the transverse processes, and are called accessory processes. The latter are pronounced in some of the lower animals as is demonstrated by the study of comparative osteology in *The P. S. C.* and serve to lock the vertebrae in this region firmly together.

3. *Normal positions and articulations.*

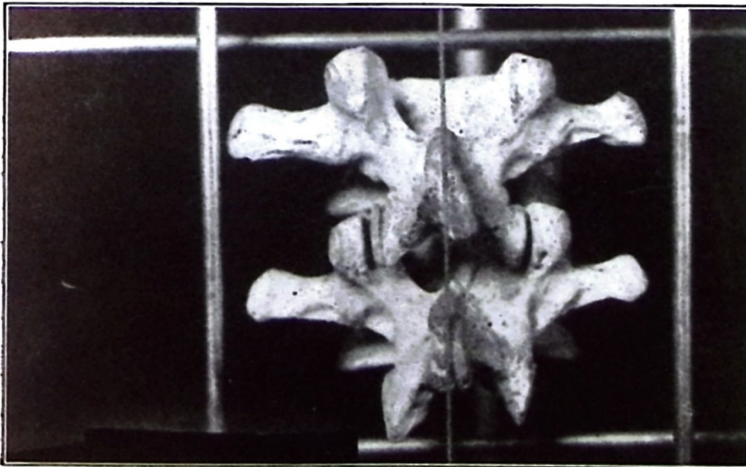


Fig. 376

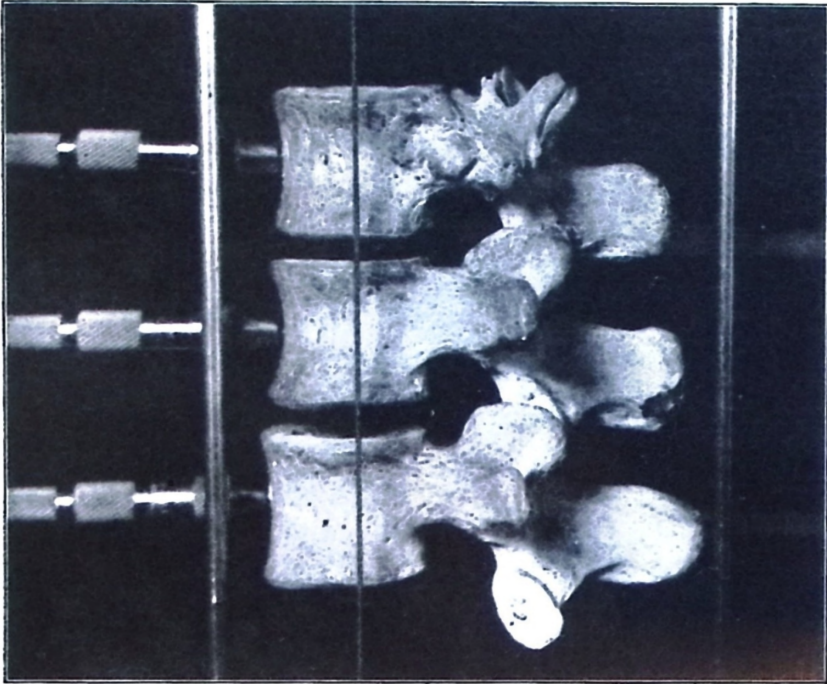


Fig. 377

The position of all the lumbar is in common to the foregoing rules, the median line. The 2nd lumbar spine is opposite the termination of the duodenum, and also opposite the commencement of the cauda equina within the spinal column.

4. *Subluxations, described and illustrated.*

The lumbar owing to their articular locks show the lateral subluxations not as great as in the dorsal and although study of the spinal skeletal column looks as if such were impossible, bear in mind that they are as common as the same in dorsal. The symptoms manifested on one or both sides, and the study of rotation around the axial line of the vertebral column prove that such are facts. The correction, by studying, relieving that trouble is sufficient proof of its existence and the plausibility of correction.

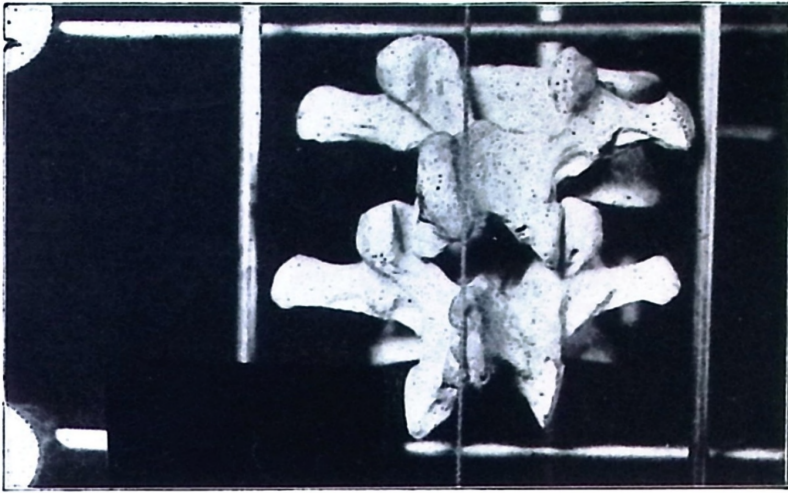


Fig. 378

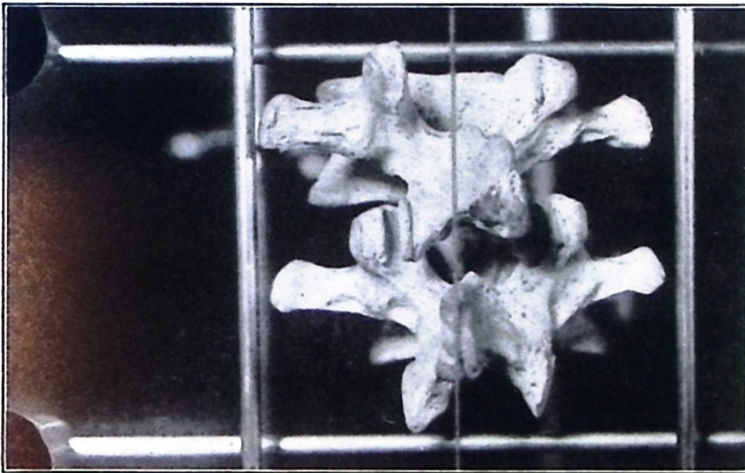


Fig. 379

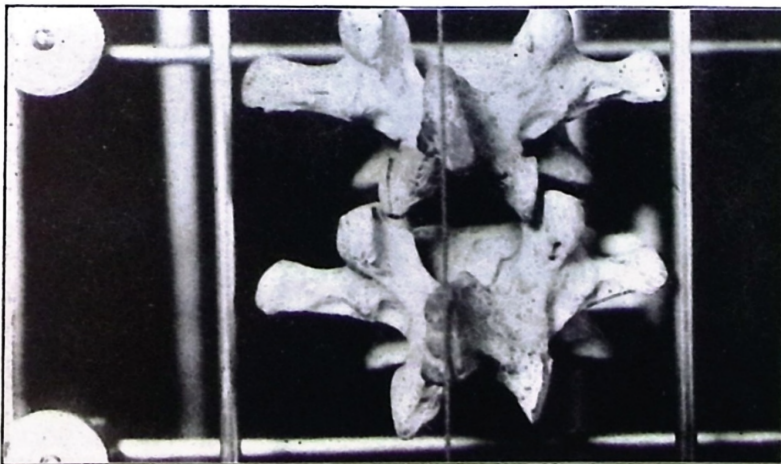


Fig. 380



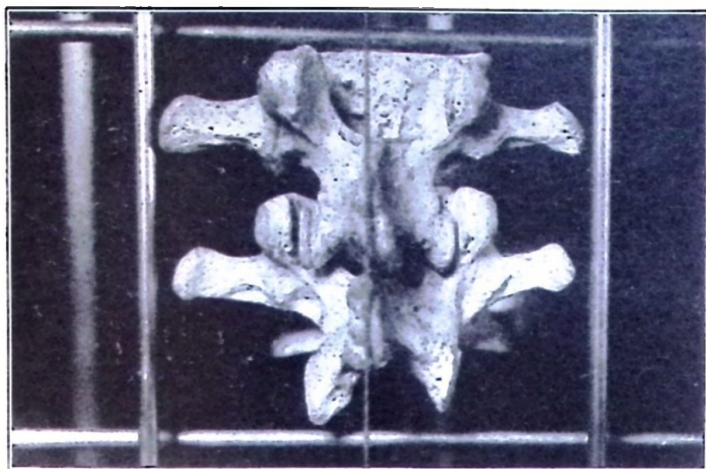


Fig. 381

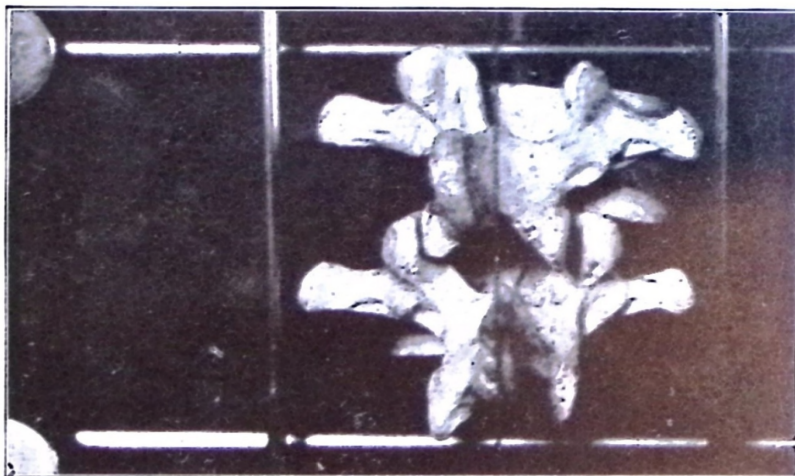


Fig. 382

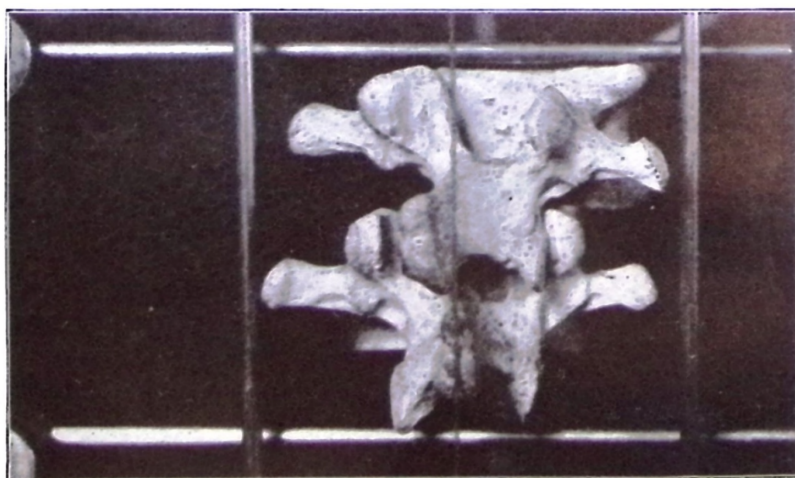


Fig. 383

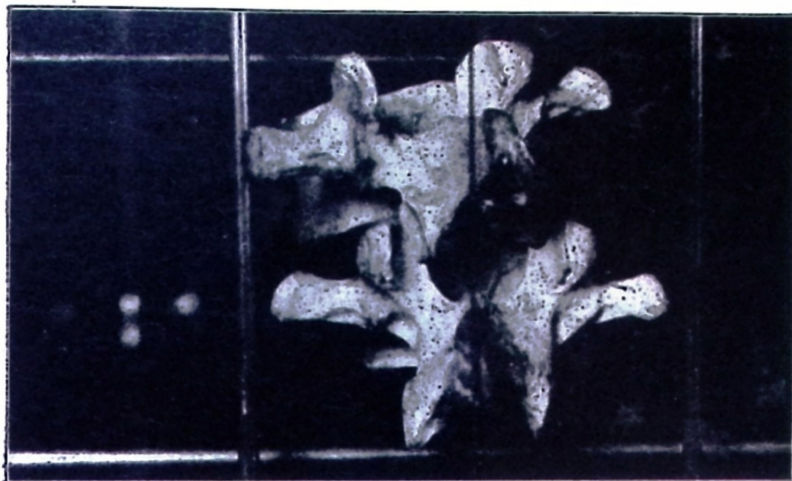


Fig. 384

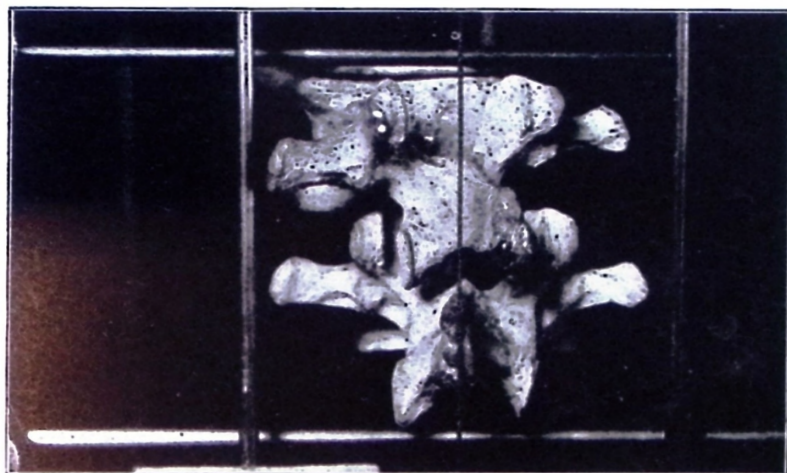


Fig. 385

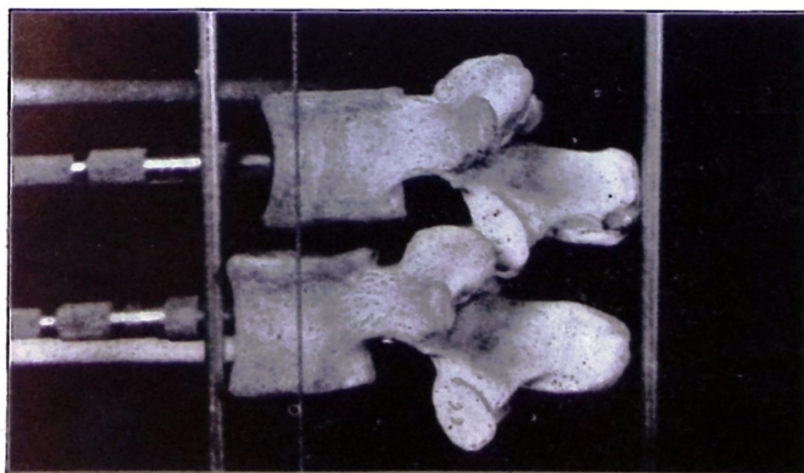


Fig. 386



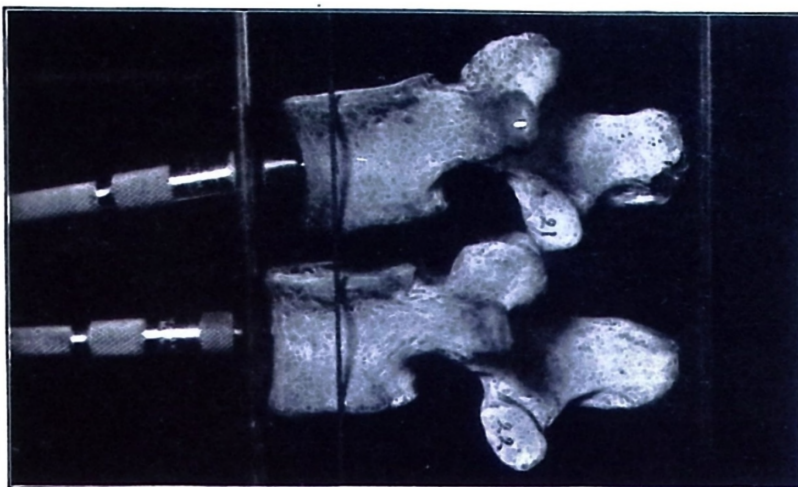


Fig. 387

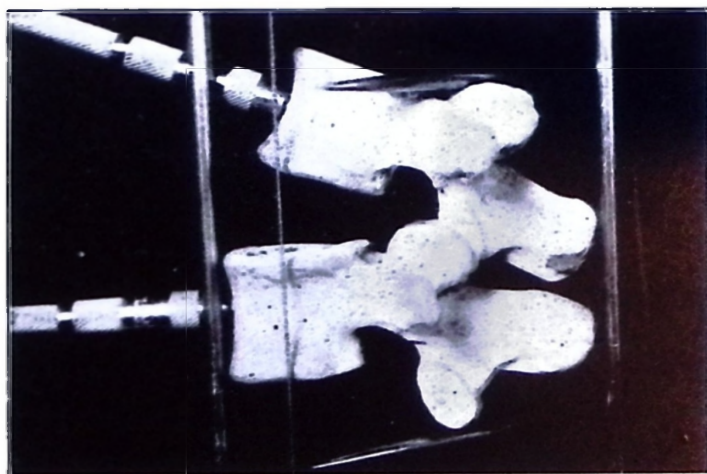


Fig. 388

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Fig. 376. Normal position of 2nd and 3rd lumbar placed within a square box. This method allows comparison between processes and rods. Whether normal or abnormal and in which way can be studied by relations.

Fig. 377. *Left* lateral view of 1st, 2nd and 3rd vertebrae for the purpose portrayed in Fig. 376.

Fig. 378. *Left* subluxation of 2nd lumbar which is



the superior vertebra. Notice comparison with plumb line and surrounding rods.

Fig. 379. *Right* subluxation of superior vertebra—the 2nd lumbar. Posterior view.

Fig. 380. *Superior* subluxation of 2nd lumbar. Compare spaces between spinous processes with the normal.

Fig. 381. *Inferior* subluxation of 2nd lumbar. Compare this with Fig. 380.

Fig. 382. *Left superior* subluxation. Notice that spinous process of superior vertebra is to the left of plumb line and also superior of normal as proven by comparison with Fig. 376.

Fig. 383. *Left inferior* subluxation of 2nd lumbar. While to the left, it is inferior to the median line.

Fig. 384. *Right superior* subluxation. Palpation would soon determine the position that his vertebra is now in. All vertebrae, especially in the lumbar, have a noticeable rotation, it is when this is excessive that we have this character of subluxations.

Fig. 385. *Right inferior* subluxation of 2nd lumbar. Notice positions and compare them carefully. The lower vertebra has, in all these abnormalities, remained fixed.

Fig. 386. *Posterior* subluxation of 2nd lumbar. Left lateral view. It is this type of subluxation that assists in decreasing the size of the foramina.

Fig. 387. *Posterior superior* subluxation. A condition met with as often as its opposite that follows.

Fig. 388. *Posterior inferior*. Compare with Fig. 387 and see difference.

---

Careful palpation will reveal that the posterior or inferior posterior subluxations are the most common. It is the deviations from this to the right or left that makes the lateral subluxations.

##### 5. *Relative positions of adjacent vertebrae.*

The relative position would be in accordance to the above description.

##### 6. *Where nerves are impinged.*

The importance of abdominal and generative organs are proportionately greater as regards size and functions

to that extent that they receive more brain fibres than any other one section of the spine. To accommodate this transmission the lumbar intervertebral foramina are larger than any other, consequently the subluxation that would produce pressures thereon are proportionately greater. The greatest decreasing of the size and shape will be by the compression from above downward or vice-versa, or, the possible tilting of a superior impingement on right superior and left inferior, a condition made prominent after nerve tracing from point of abnormal expression to location of impingement, where the above results are noticeable. Further palpation of the spinous process compared with the transverse but prove it to be a fact.

7. *How and what makes pressures.*

8. *Functions and organs involved. Location of—*

P. P. is prominent inasmuch as thru this region pass outward all those brain fibres which transmit the Innate intellectual functioning power of every organ, and tissue in the abdomen even going so far as to convey those impulses which express action in the abdominal walls. The substance of the vertebrae themselves are supplied by fibres which emit thru corresponding foramina.

Every function that is common to the body in general is noticeable in this region and in addition one more which is not in other portions viz:—reproduction.

Adjusting the lumbar vertebrae for diseases of pregnant persons is permissible if the individual is suffering pain or discomfort, great or little, in those organs that have to do with some functions. Great care and discretion must be used in determining who should not be adjusted under such circumstances. The patient who relaxes easily and freely could be adjusted up to the very day of delivery providing the adjustment is given with freedom and caution. The person who contracts the muscles of the spine and abdomen under adjustment, whether pregnant or not, would be a poor subject to adjust at any stage of this process for forced adjustments are most damaging, pregnant or not, therefore might do more harm than good.

The greatest reports of damages that pseudos are doing in the field is from a misunderstanding of how to get the patient to relax. They aim to force the adjustment, abnormal results are increased as a consequence.

I have had reported to me, many cases, in this condition, that have been permanently injured and the use of the uterus and ovaries ruined for the lack of care in how the adjustment was given. Have your table widely divided with the thighs highly raised. *The P. S. C.* has carried many cases under adjustment in this manner to the very day of uterine expulsion in a painless and free manner. The thighs and abdomen should, at all times be far removed from touching anything that those portions be not jarred or directly concussed with any hard substances underneath, yet with all, the thighs must be placed on something solid to make the light adjustment a possibility.

9. *Adjustments necessary to correct each.*

10. *How to give adjustments correctly.*

As mentioned the transverse processes are usually flat from anterior to posterior therefore are subject to easy fracture especially if the subluxation be a severe one and there be any exostotic locks or ankyloses. The spinous processes are on the reverse, the largest, strongest in the body, therefore greater leverage can be had for a lateral adjustment. As before mentioned, I prefer the use of the spinous all thru as it holds primarily to the simplicity of *P. S. C.* teachings which is to abbreviated as far as possible as is consistent with demonstrable results. Have one common basis and hold to that in preference to manufacturing such a jargonity of words and movements that mystifies the student.

The thinker will observe that the larger number of diseases studied are followed in this region by strong, massive exostoses and ankyloses. There are more dorsal vertebrae and these have the costal to assist in what might be termed artificial bracing but in the lumbar this entirely absent therefore its place is taken with exostoses. For the relative space the exostoses that is deposited at, around or between lumbar vertebrae is greater, solidity,



condensation is more and of the specimens studied you will notice they have with it a more metallic ring.

12. *What diseases to adjust the 1st and 2nd lumbar for.*

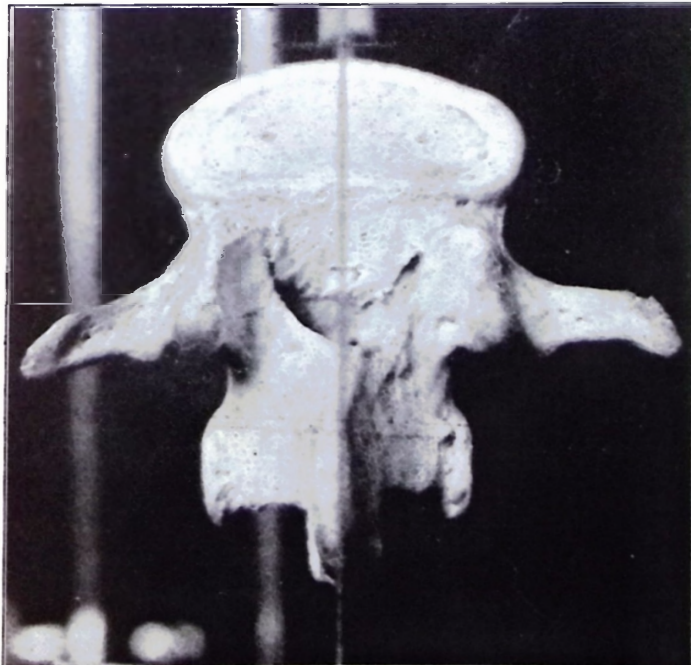
The corresponding point of the preceeding chapter answers this also.

*CHAPTER 24.*

**3-4 AND 5TH LUMBAR.**



**Fig. 389.** Enlarged view of 3rd lumbar vertebra.



**Fig. 390.** Enlarged view of 4th lumbar.

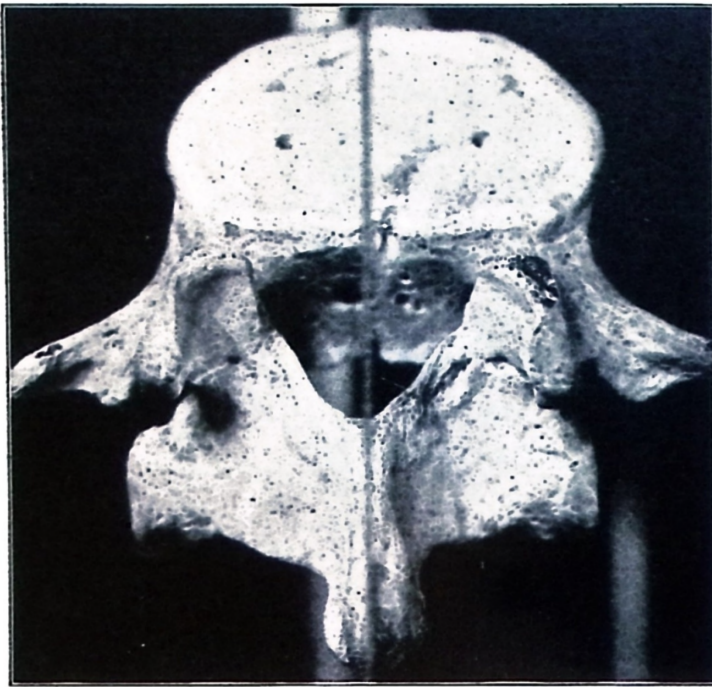


Fig. 391. Enlarged view of 5th lumbar.

1. *Vertebrae and their titles. P. P. or U. R. P. and L. P. P. or R. P.*

Having its origin in the fact of one case of constipation in which an adjustment at this place had the bowels in action before the party could reach the bath room. You may rest assured that he *ran*, and when research in these investigations were going on this was named as above, although in recent years it has been better known as a *Rectal Place*.

2. *Superficial palpation and landmarks.*

The 4th lumbar spine is opposite the termination of the abdominal aorta.



Placing the first fingers upon the crest of each ilium and drawing a horizontal line will reach at some portion of the 4th lumbar spine, from which the soundings can be made, above or below. The 5th lumbar vertebra is different from its fellows in having the body much thicker in front than behind, forming, when articulated with the sacrum, the sacro vertebral promontory and in approaching in character the upper sacral vertebra in the great size of its transverse processes and in the wide interval between the inferior articular processes.

3. *Normal positions and articulations.*

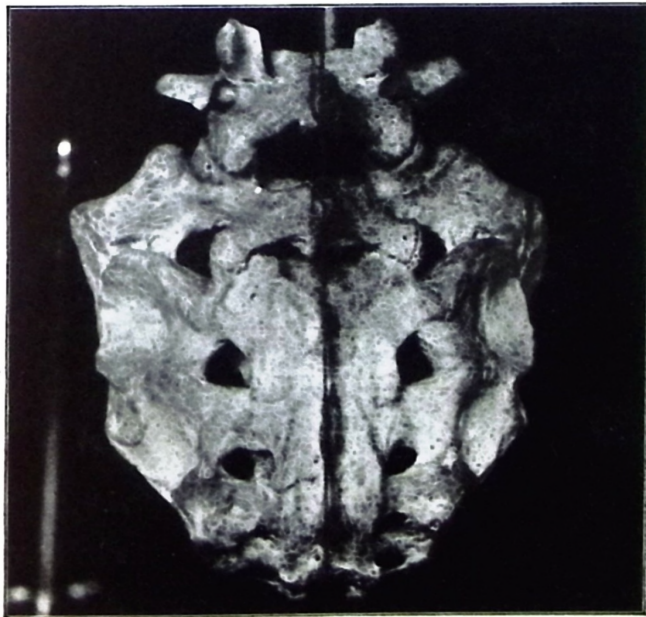


Fig. 392. *Posterior view of 5th lumbar and sacrum.*  
Normal.

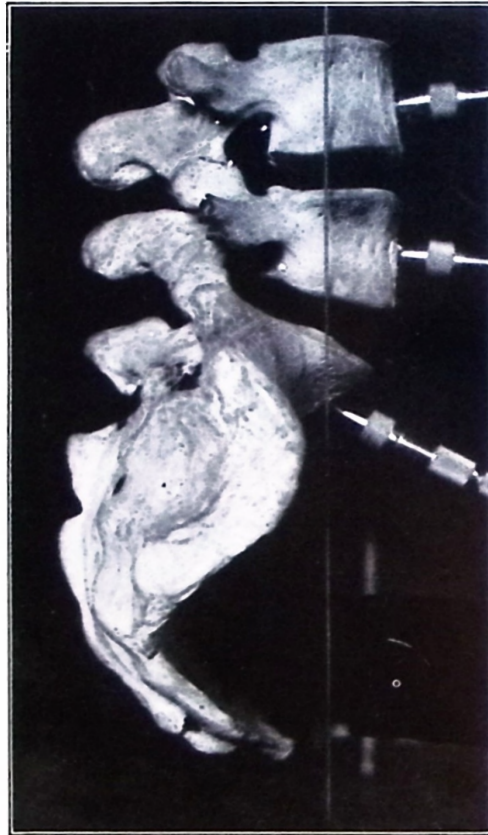


Fig. 393. *Right lateral view of 4th and 5th lumbar vertebrae and sacrum. Normal.*

4. *Subluxations, described and illustrated.*

The subluxations that exist with the 4th lumbar is in common with other lumbar although the 5th has on distinction, viz:—it will be posterior and to one side or the other. The posterior aspect of this vertebra becomes more noticeable here than in other lumbar vertebrae.

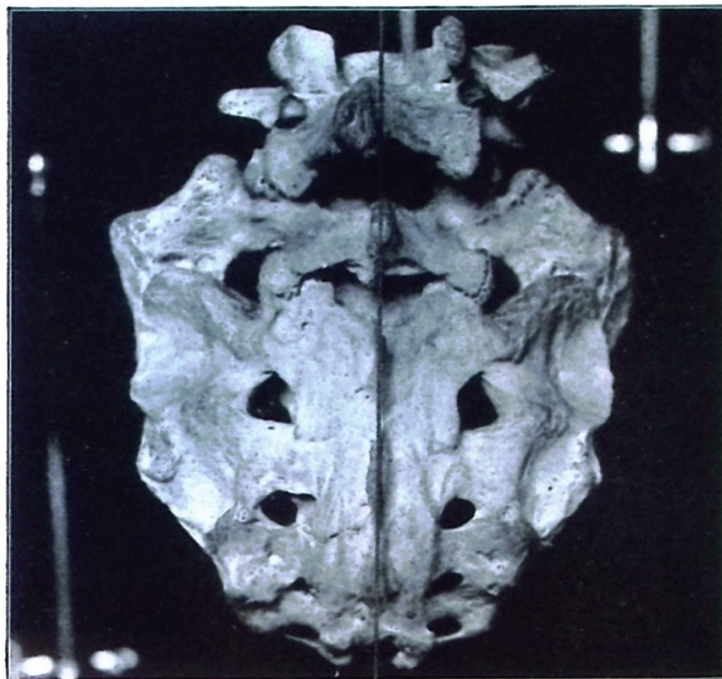


Fig. 394

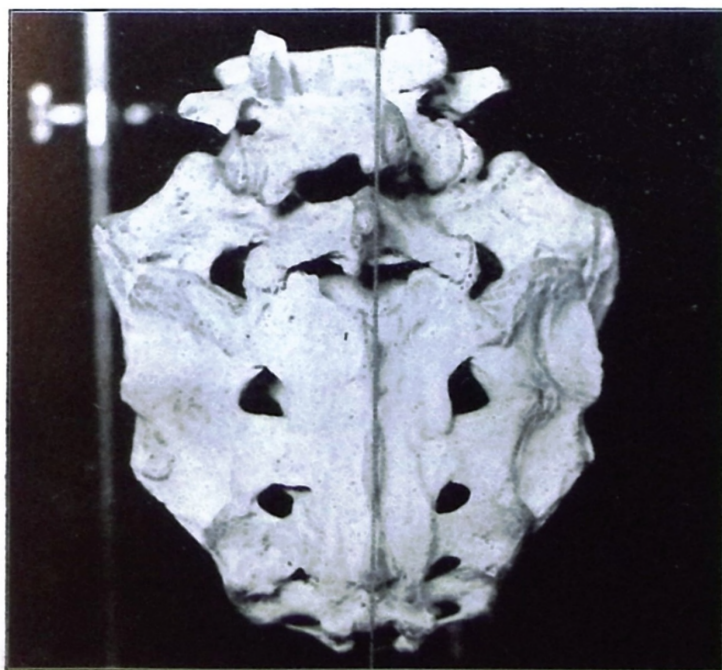


Fig. 395



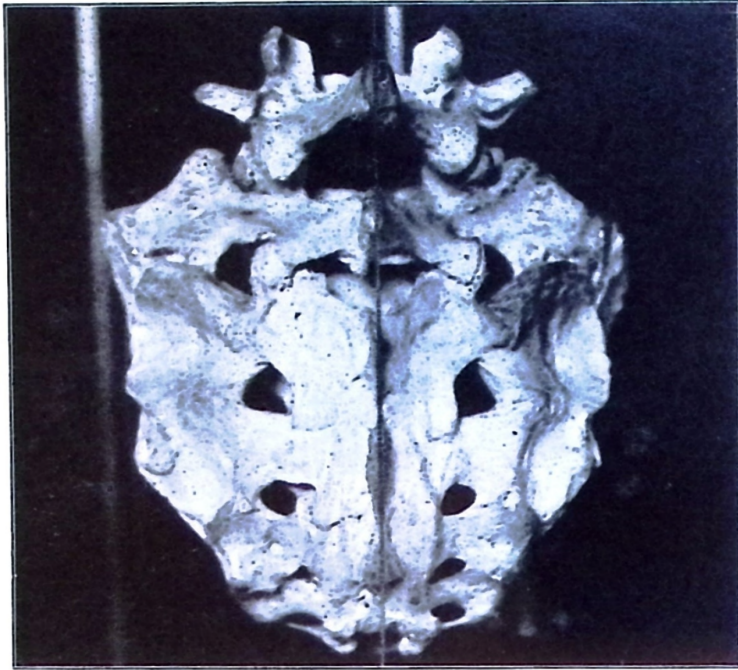


Fig. 396

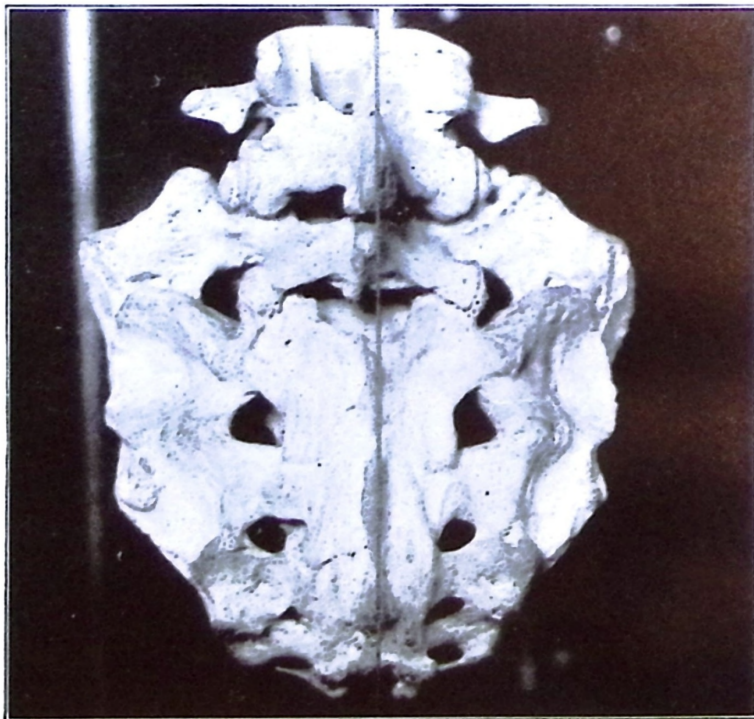


Fig. 397

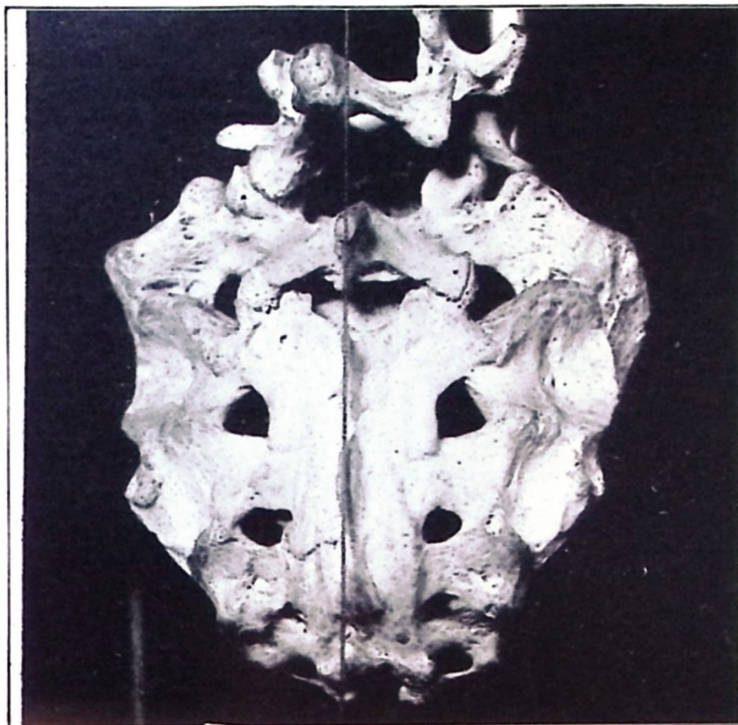


Fig. 398

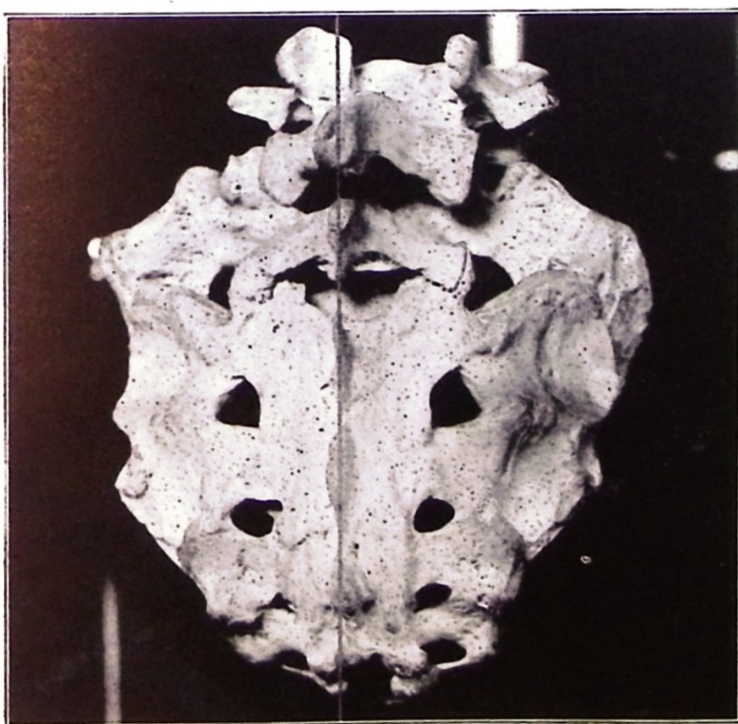


Fig. 399



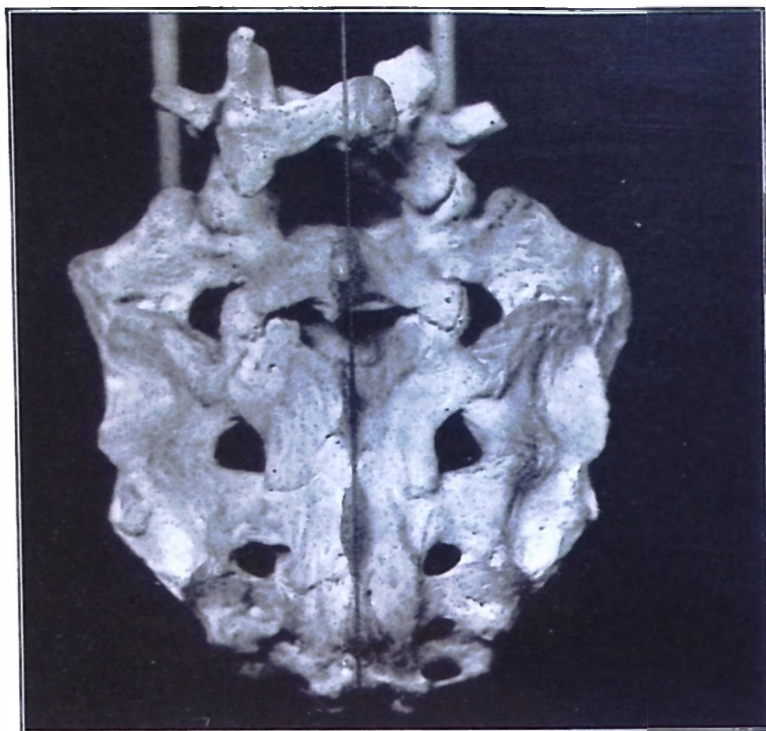


Fig. 400

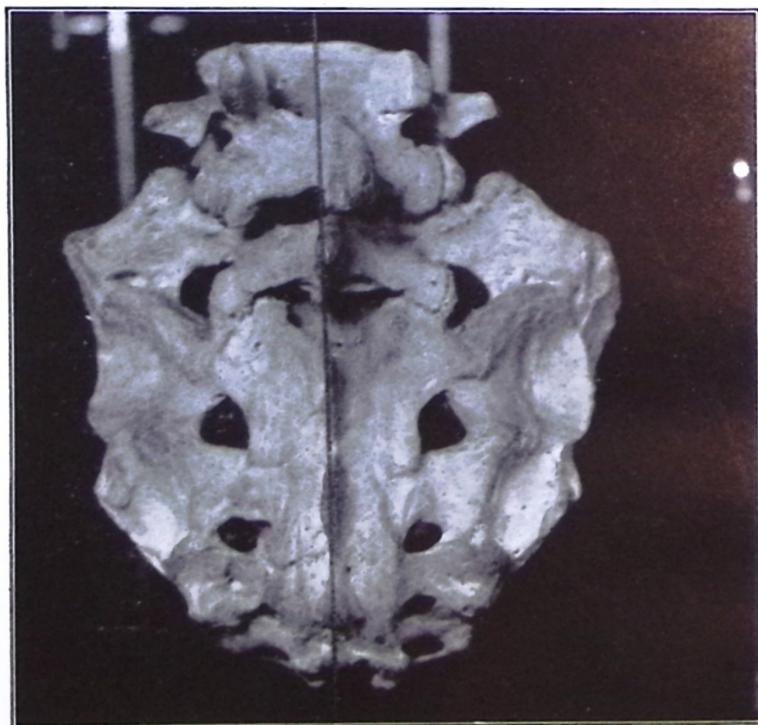


Fig. 401



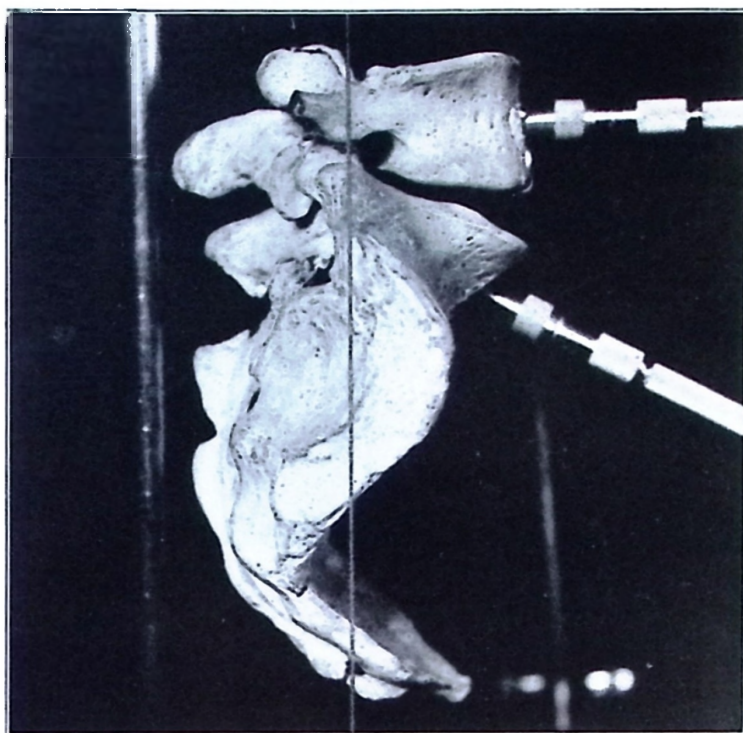


Fig. 402

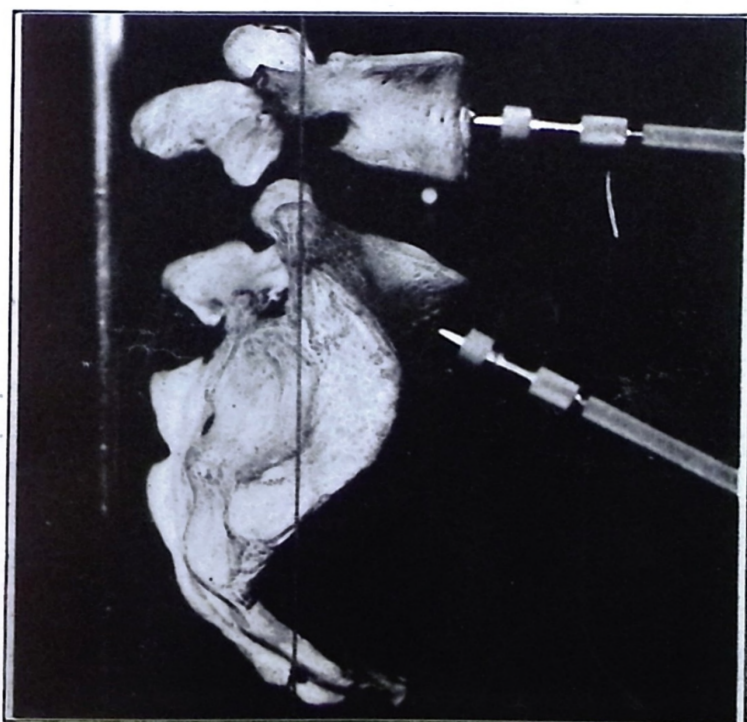


Fig. 403

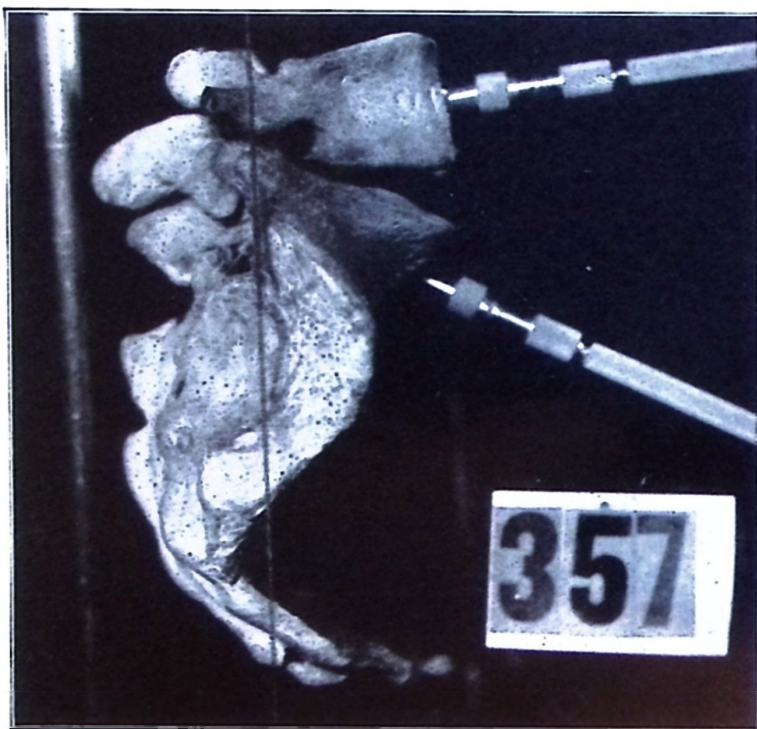


Fig. 404

Fig. 394. *Left subluxation of 5th lumbar. Posterior view.*

Fig. 395. *Right subluxation of 5th lumbar. Study plumb line and the comparisons thruout this set.*

Fig. 396. *Superior subluxation of 5th lumbar.*

Fig. 397. *Inferior subluxation of 5th lumbar.*

Fig. 398. *Left superior subluxation of 5th lumbar.*

Fig. 399. *Left inferior subluxation of 5th lumbar.*

Fig. 400. *Right superior subluxation of 5th lumbar.*

Fig. 401. *Right inferior subluxation of 5th lumbar.*

Fig. 402. *Posterior subluxation of 5th lumbar.*

Fig. 403. *Posterior superior subluxation of 5th lumbar.*

Fig. 404. *Posterior inferior subluxation of 5th lumbar.*

5. *Relative positions of adjacent vertebrae.*
6. *Where nerves are impinged.*

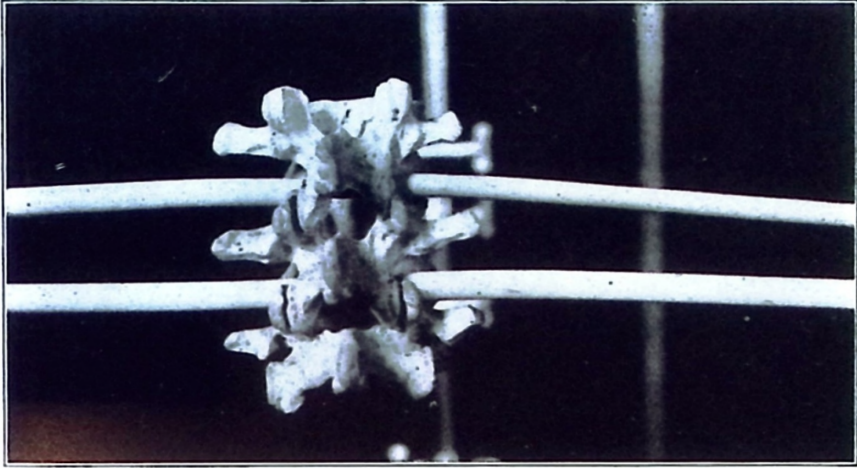


Fig. 405

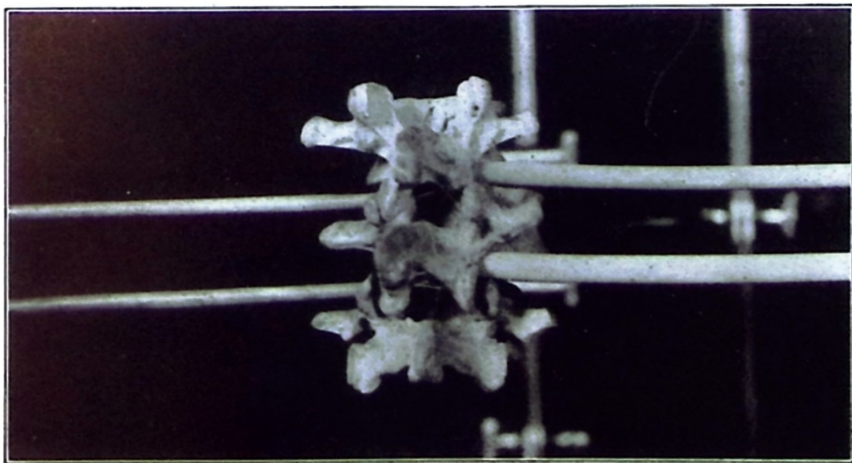


Fig. 406



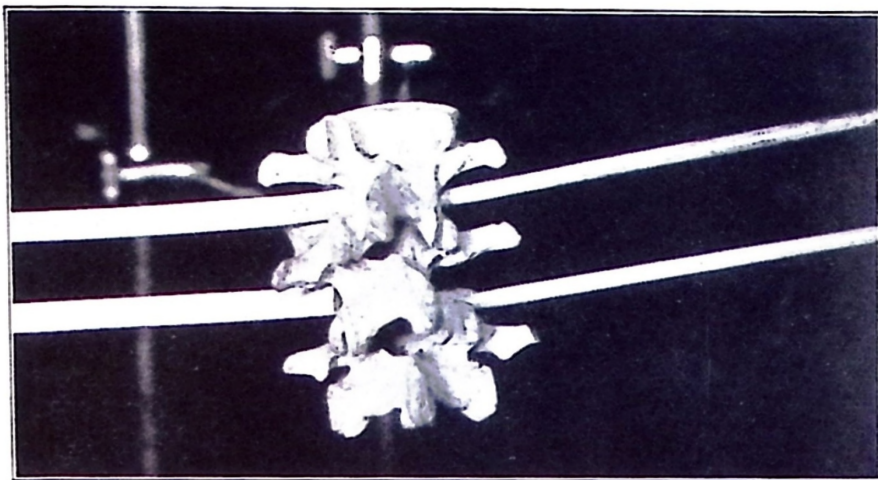


Fig. 407

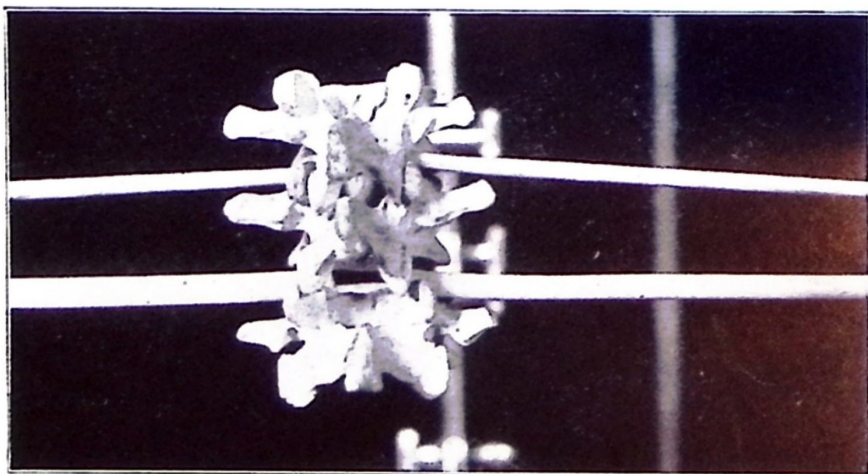


Fig. 408

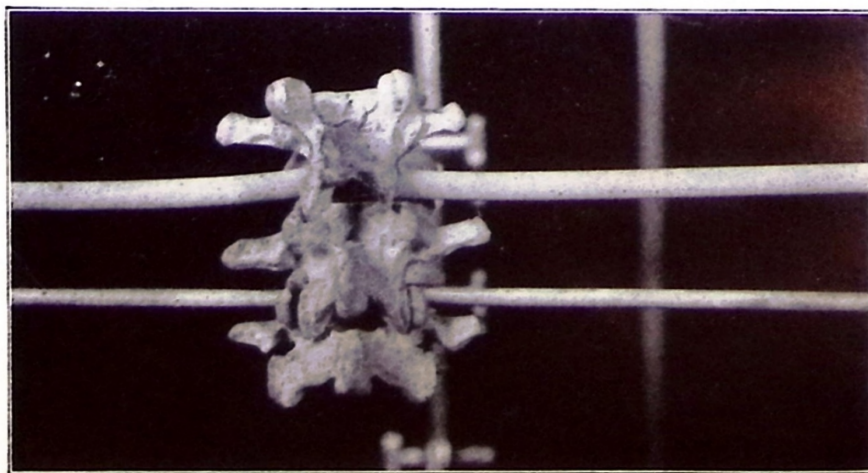


Fig. 409

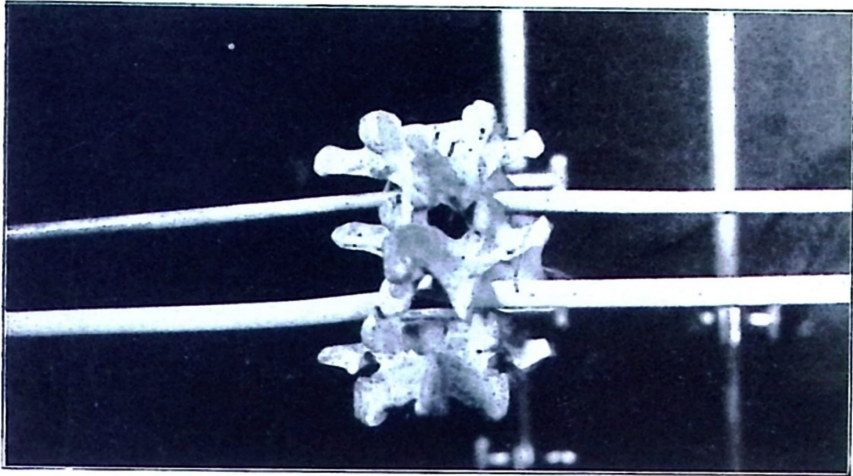


Fig. 410

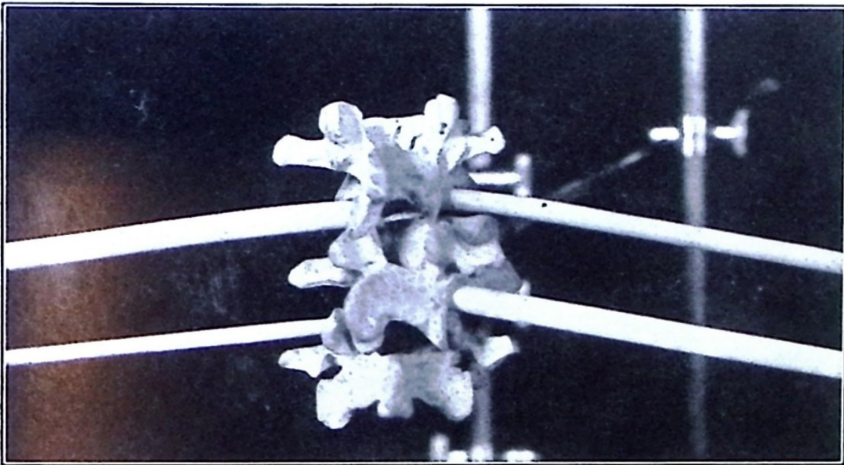


Fig. 411

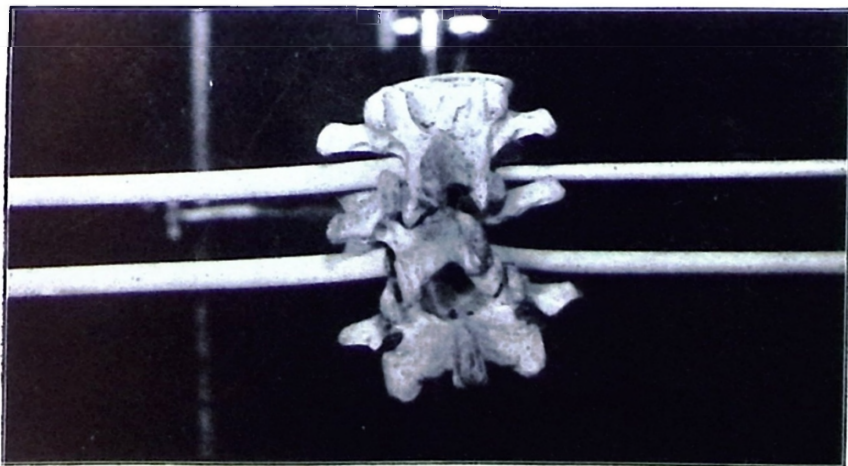


Fig. 412



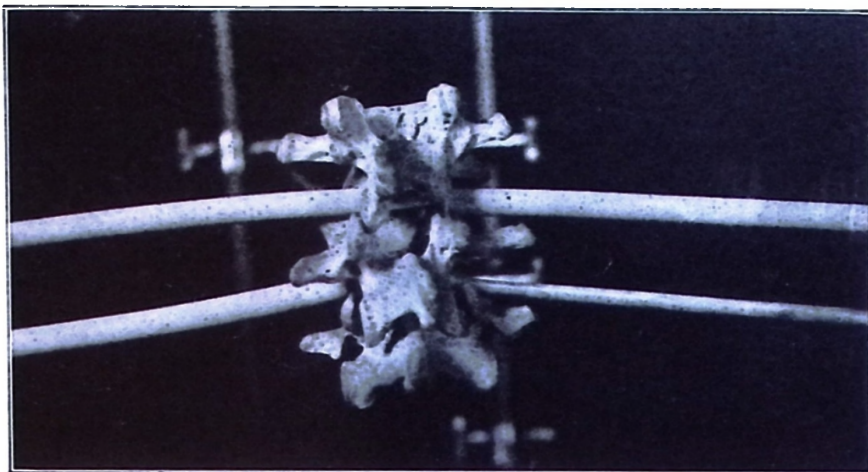


Fig. 413

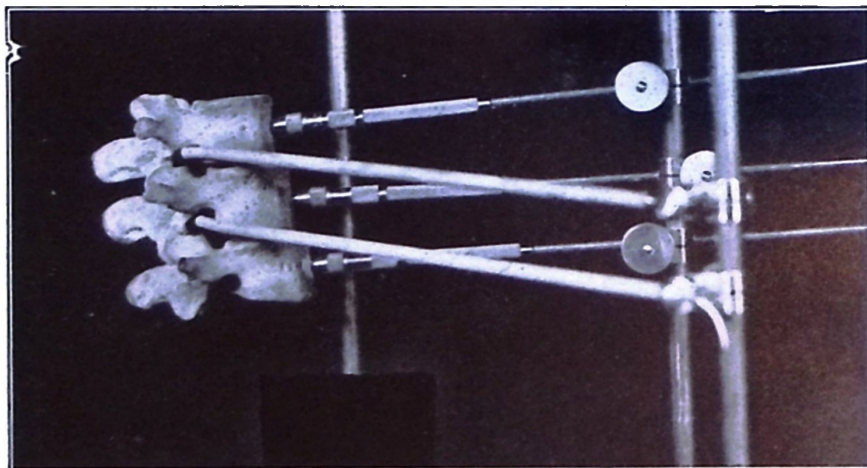


Fig. 414

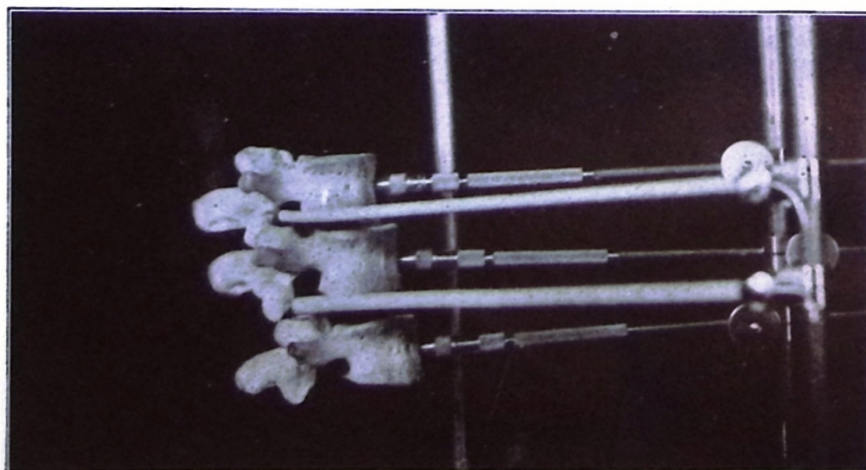


Fig. 415



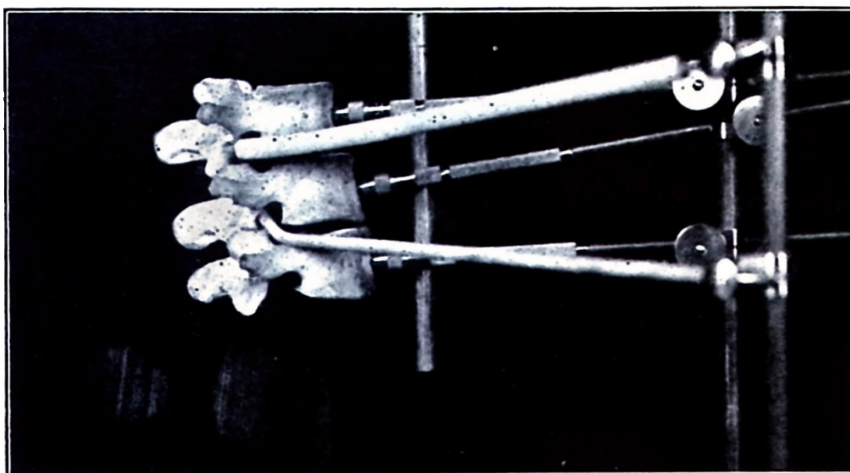


Fig. 416

Fig. 405. 3rd, 4th and 5th lumbar. Posterior view. Four normal nerves issuing from the intervertebral foramina.

Fig. 406. *Left* subluxation of 4th lumbar showing pressure upon nerves issuing from between the 3rd and 4th, and 4th and 5th on left side.

Fig. 407. *Right* subluxation of 4th lumbar to show the opposite to Fig. 393 not only in subluxation but in pressures.

Fig. 408. *Superior* subluxation of 4th lumbar showing pressures upon both superior foramina to the 4th lumbar.

Fig. 409. *Inferior* subluxation of 4th lumbar producing pressures upon both lower nerves.

Fig. 410. *Left superior* subluxation of 4th lumbar producing pressures upon the nerves emitting thru left superior foramina to 4th lumbar.

Fig. 411. *Left inferior* subluxation of 4th lumbar. Similar, as to side, as the preceding but inferior.

Fig. 412. *Right superior* subluxation of 4th lumbar. Pressure upon nerve having its exit superior to 4th lumbar on right side.

Fig. 413. *Right inferior* subluxation of 4th lumbar.

bar. Pressure is opposite to the above. Instead of being superior to the vertebrae on that side, it is inferior.

Fig. 414. *Posterior* subluxation of 4th lumbar. Right lateral view. Both nerves are impinged.

Fig. 415. *Posterior superior* subluxation of 4th lumbar. Right lateral view. Superior foramen is occluded and diminished in size and shape hence smaller, consequently pressure exists.

Fig. 416. *Posterior inferior* subluxation of 4th lumbar. The pressure is the reverse of what it was in Fig. 402.

---

7. *How and what makes pressures.*

8. *Functions and organs involved. Location of—*

As a general rule it can be said the higher the zone affected in abdomen and legs, the higher in the lumbar is the subluxation. If the disease be located in the bowels proper or in the approximate region of the knee its cause would be located at M. P. P. or if the affection be in the feet or lower abdominal region as rectum etc., etc., the lower lumbar will divulge the secret.

9. *Adjustments necessary to correct each.*



Fig. 417



Fig. 418



Fig. 419



Fig. 420





Fig. 421

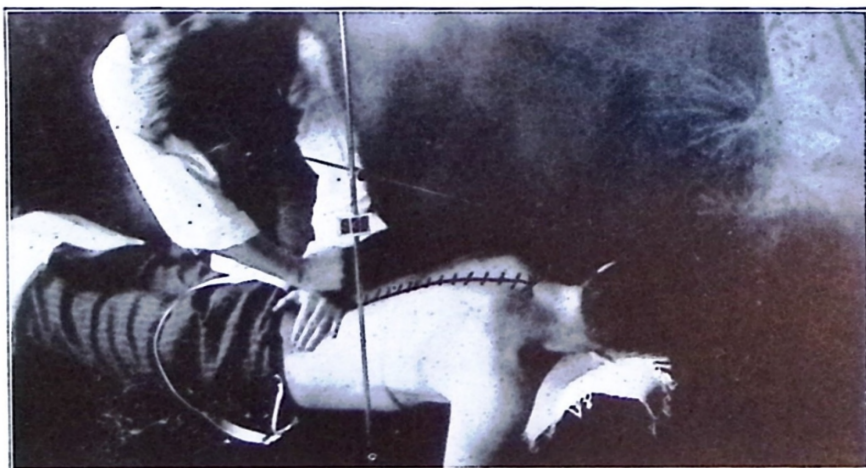


Fig. 422



Fig. 423

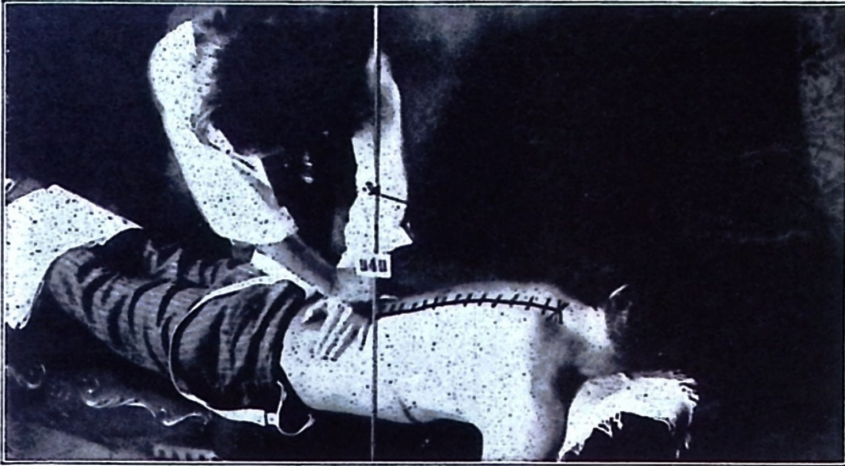


Fig. 424

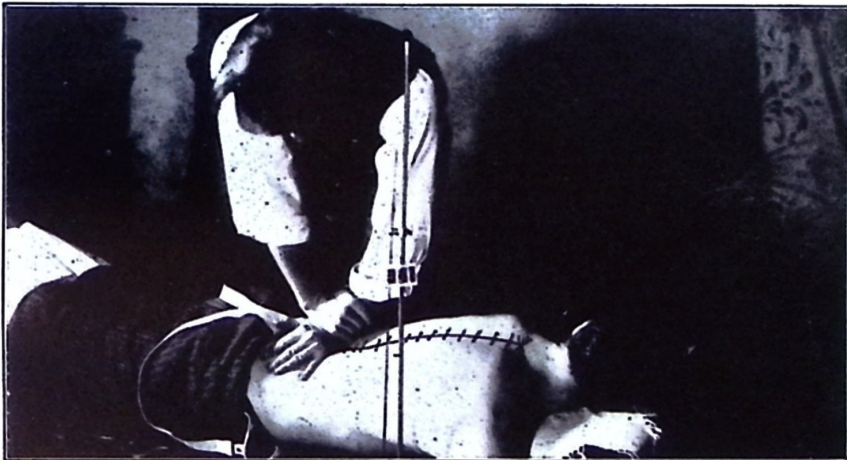


Fig. 425



Fig. 426





Fig. 427

Fig. 417. *Left* subluxation with its adjustment to the *right*.

Fig. 418. *Right* subluxation with its adjustment to the *left*.

Fig. 419. *Superior* subluxation of 3rd lumbar with its adjustment to the *inferior*.

Fig. 420. *Superior* subluxation of 3rd lumbar with its adjustment to the *superior*.

Fig. 421. *Left superior* subluxation with its adjustment to the *right inferior*.

Fig. 422. *Left inferior* subluxation with its adjustment to the *right superior*.

Fig. 423. *Right superior* subluxation with its adjustment to the *left inferior*.

Fig. 424. *Right inferior* subluxation with its adjustment to the *left superior*.

Fig. 425. *Posterior* subluxation of 3rd lumbar with its adjustment to the *anterior*.

Fig. 426. *Posterior superior* subluxation of same vertebra with its adjustment to the *anterior inferior*.

Fig. 427. *Posterior inferior* subluxation of 3rd lumbar with its adjustment to the *anterior superior*.

10. *How to give adjustments correctly.*

11. *What means, and portions, thereof to use.*

12. *What diseases to adjust this vertebra for.*

Rheumatism of the legs, hemorrhoids, prolapsus of the rectum, running sores of the legs, etc., etc., milk leg, leg cramps.



*CHAPTER 25.*  
**SACRUM.**

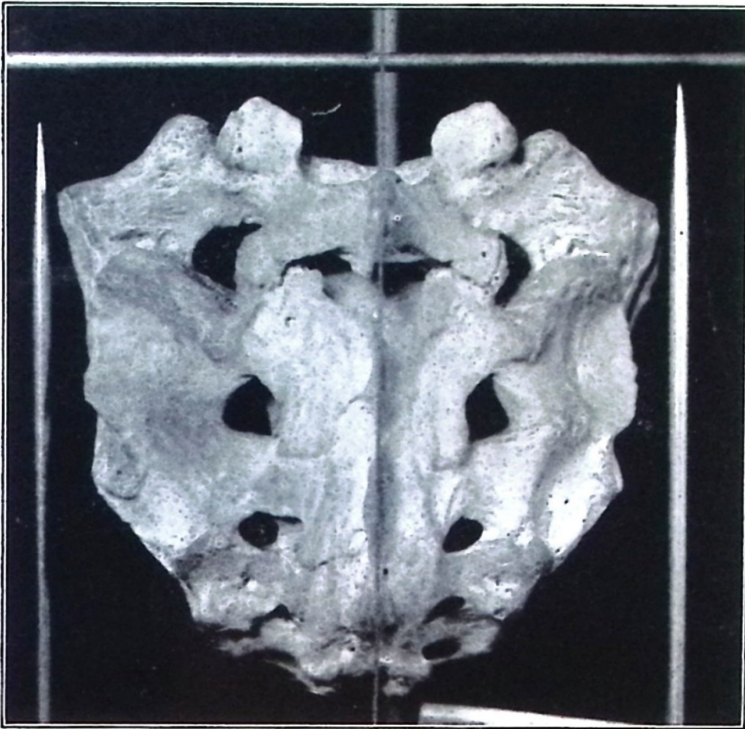


Fig. 428



Fig. 429

1. *Vertebrae and its title. Sa. P.*
2. *Superficial palpation and landmarks.*

Closely imbedded as it is between the two ilii and the fifth lumbar and forming as it were a superior wedge between the two it may seem as tho subluxations of it is an impossibility. Close careful palpation will reveal the facts that the superior surface or its base may be elevated upon one side or the other or one lateral half may be more anterior than the other but the most usual subluxation is the posterior or anterior position of the sacro-vertebral angle and it is known that the 5th lumbar and the sacrum form a sacro-vertebral angle and it is quite common to find this angle in excess or not enough to give the body the rotundity necessary to have superior equilibrium. The spinous processes of the 5th and 1st of the sacrum may be quite prominent, posteriorly or the reverse, giving the appearance of an anterior subluxation of the 5th lumbar.

3. *Normal position and articulations.*

See Fig 428 which is normal.

4. *Subluxations described and illustrated.*

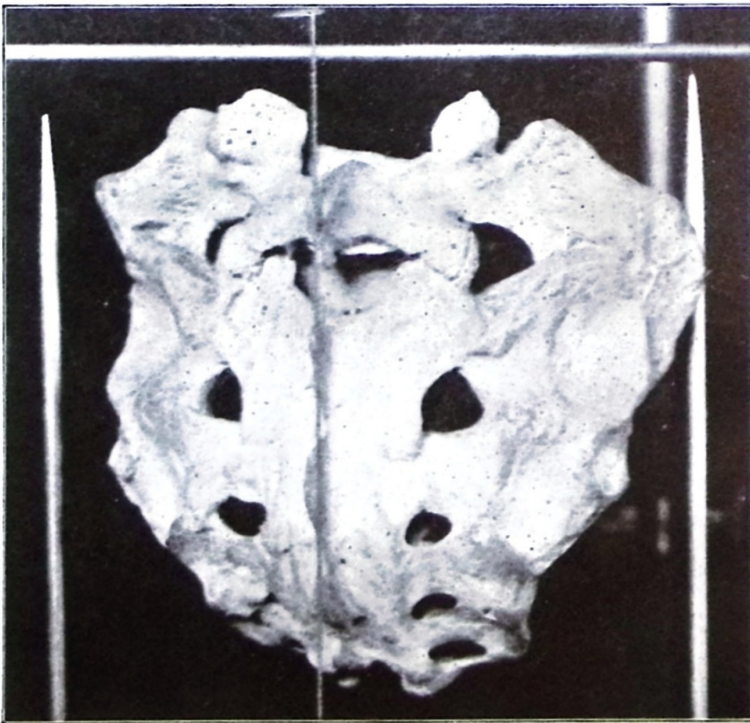


Fig. 430



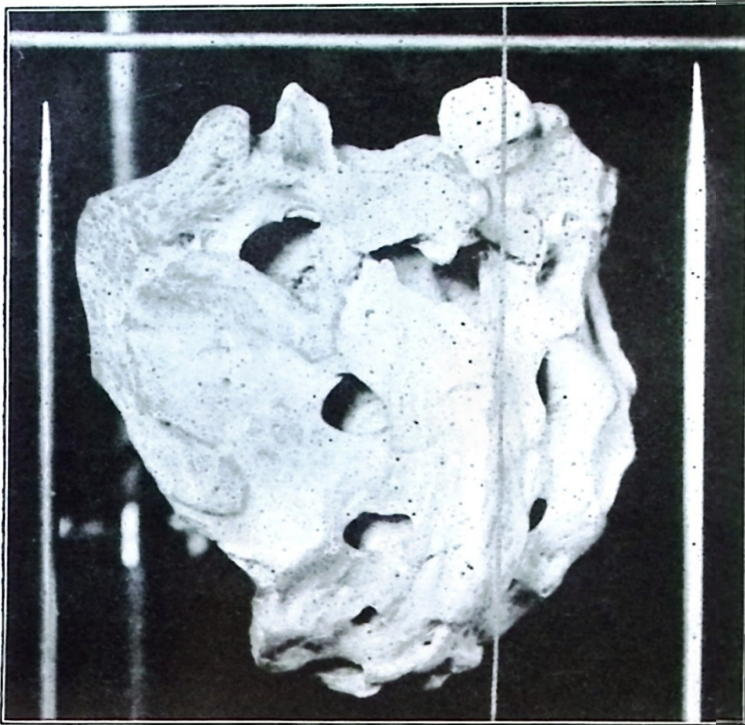


Fig. 431

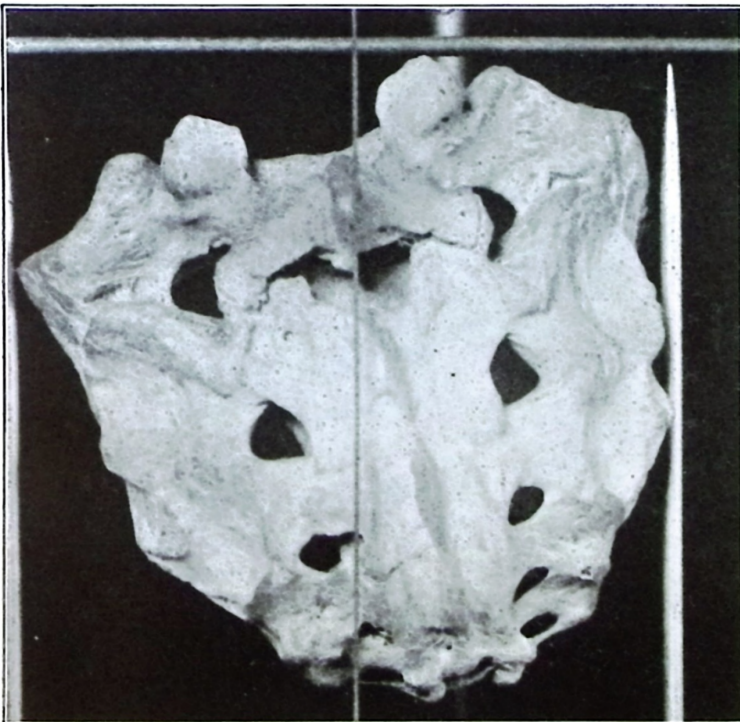


Fig. 432



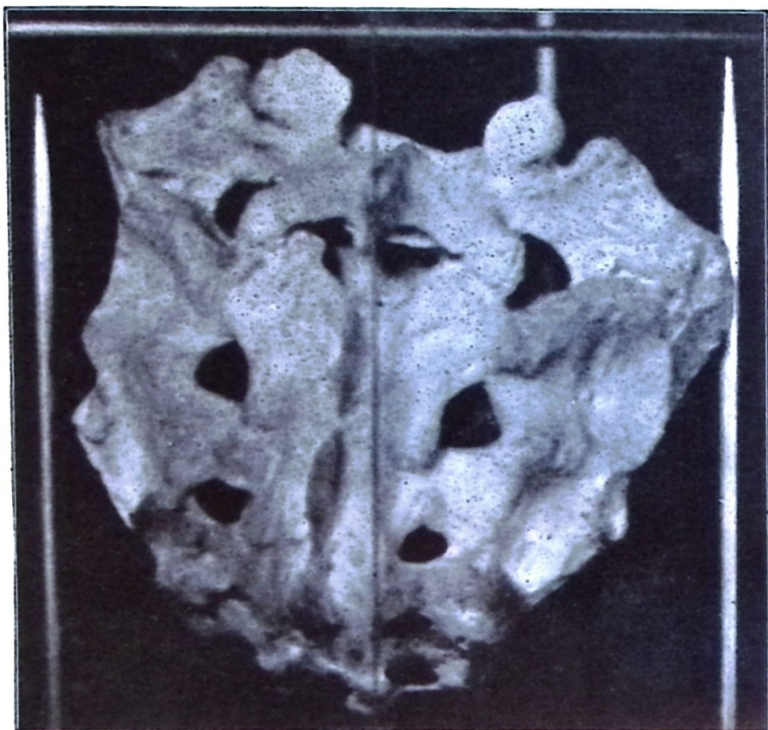


Fig. 433

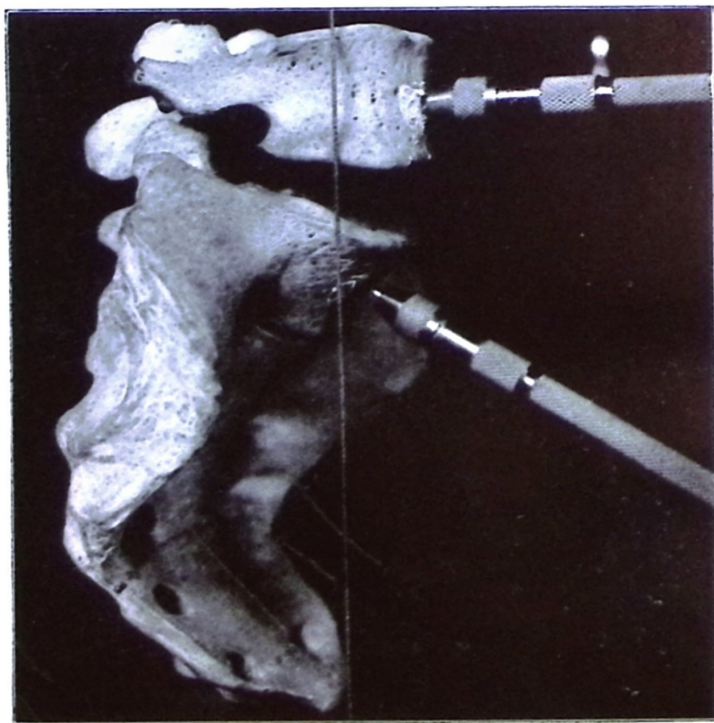


Fig. 434

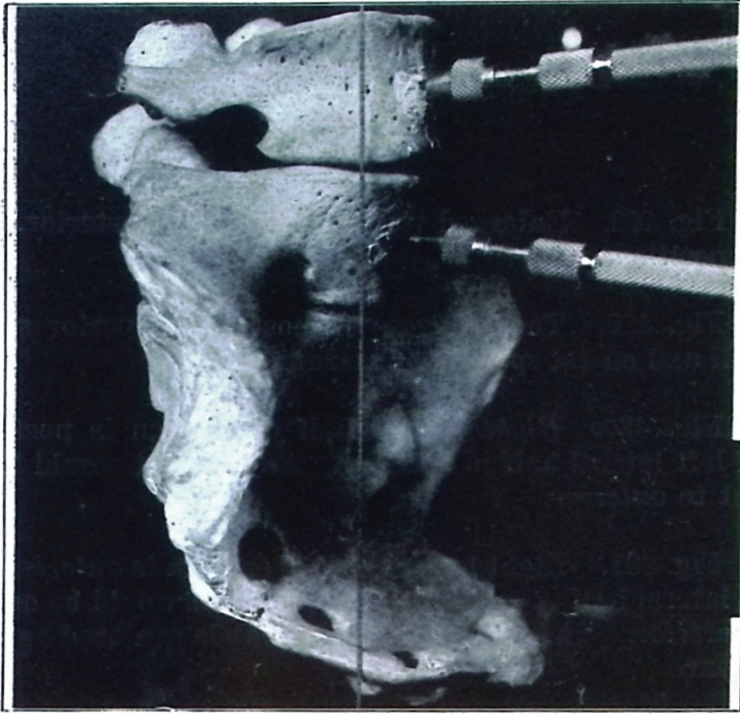


Fig. 435

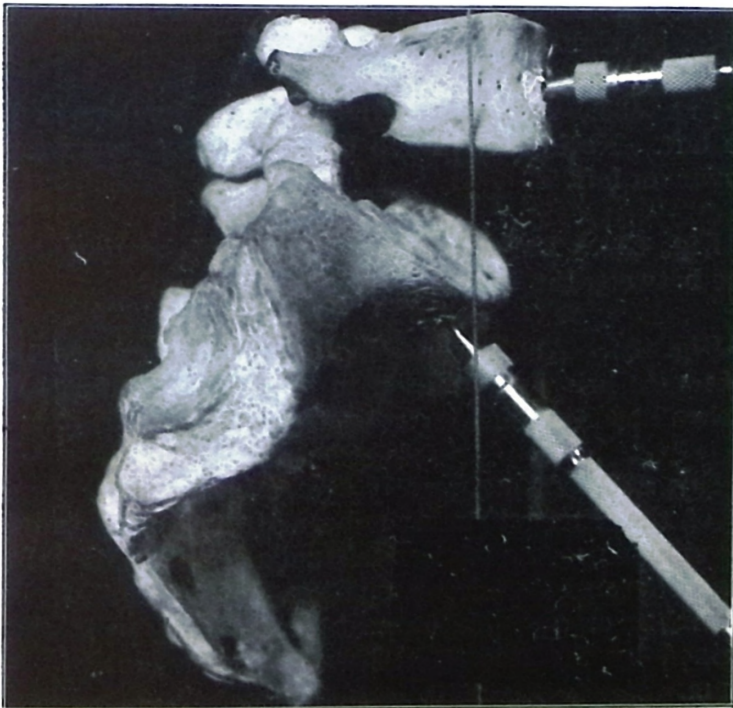


Fig. 436

Fig. 428. Enlarged view of Sacrum. Posterior. Normal position.

Fig. 429. Three fingers on posterior superior spines of ilii and on 1st spinous of sacrum.

Fig. 430. *Right* lateral half of sacrum is posterior and left lateral half is *anterior*. Adjustment would be on right to *anterior*.

Fig. 431. Right lateral half of sacrum is *anterior* and left lateral half is *posterior*. Adjustment would be on left to *anterior*. The same portions of hands are used as with lumbar.

Fig. 432. *Right* articulation with lumbar is higher than left. Notice plumb line does not bisect the spinous processes of all 5 sacral vertebrae. Adjustment would be *inferior* on right.

Fig. 433. *Right* articulation with lumbar is lower than left. Notice the plumb line. Adjustment would be *inferior* on left.

Fig. 434. Lateral *posterior* angle showing normal space between the fifth lumbar and sacrum.

Fig. 435. Angle made *smaller* by the angle portion of the sacrum being subluxated to the *anterior*. 5th lumbar vertebra has remained as a fixed point.

Fig. 436. Angle greatly increased by the lower portion of the sacrum having been subluxated *posteriorly*. The spinous process of the 5th lumbar and 1st sacral show these differences under palpation. Whether inferior of 5th lumbar or anterior or posterior of sacrum is also determined by the additional knowledge of the inferior of sacrum.



5. *Relative position of adjacent vertebrae.*
6. *Where nerves are impinged.*

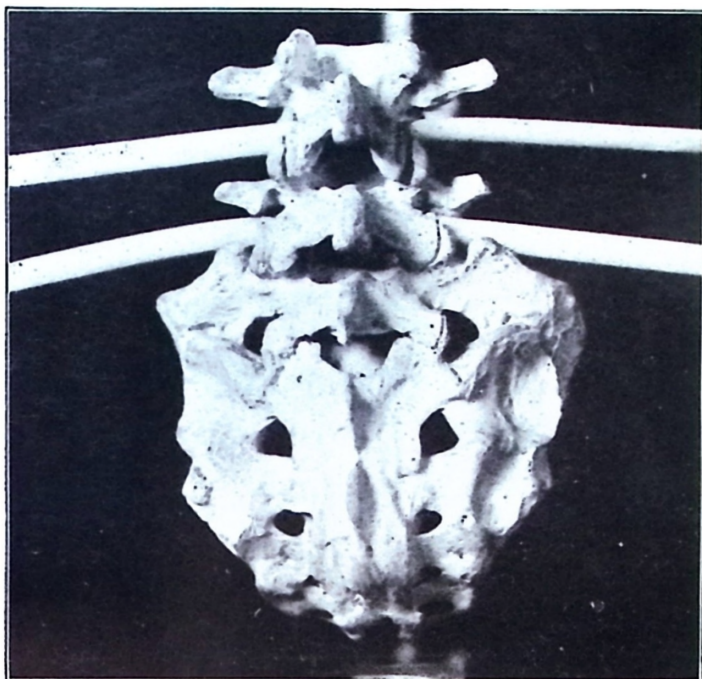


Fig. 437

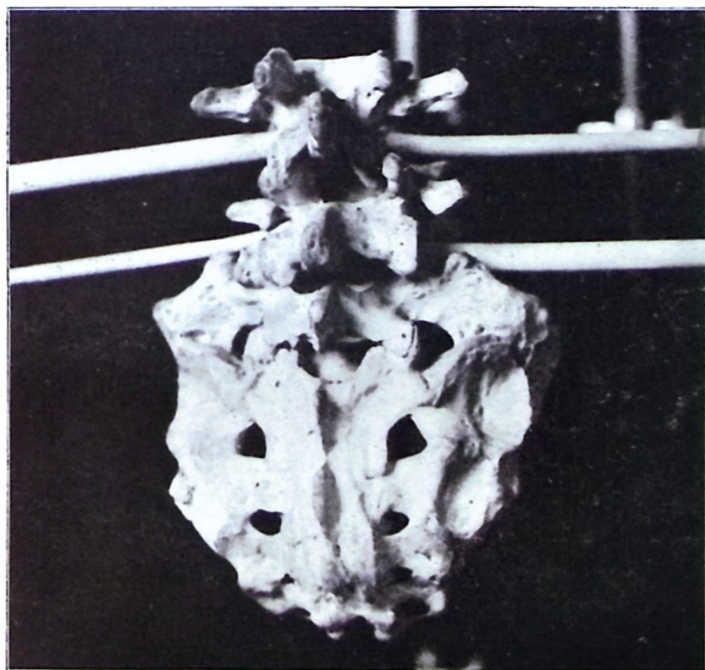


Fig. 438

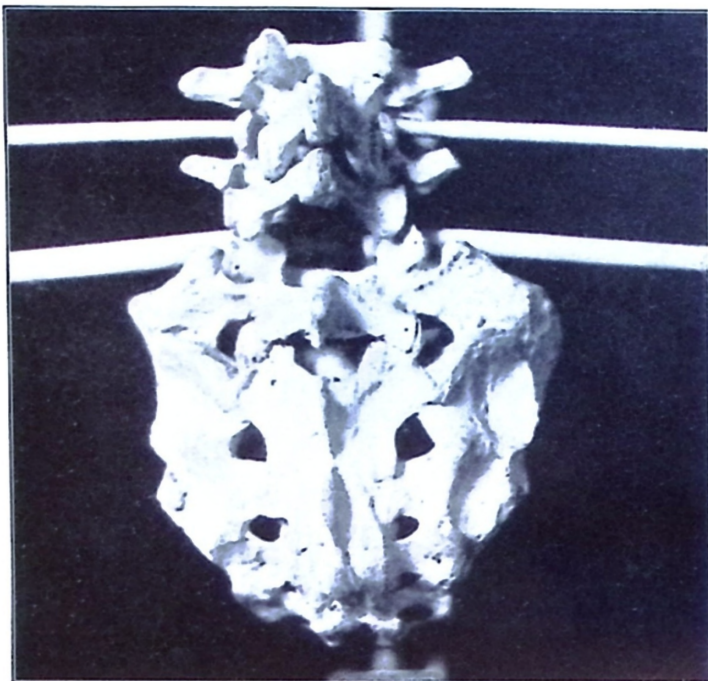


Fig. 439

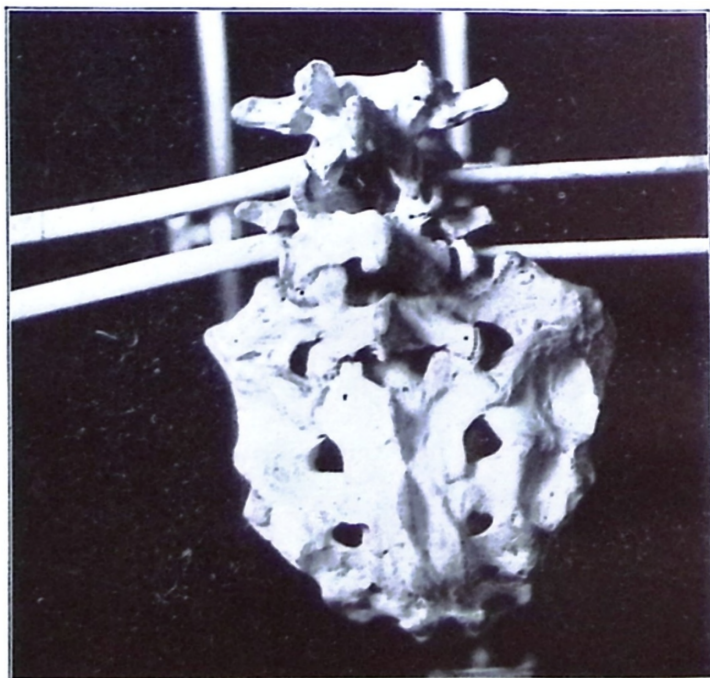


Fig. 440

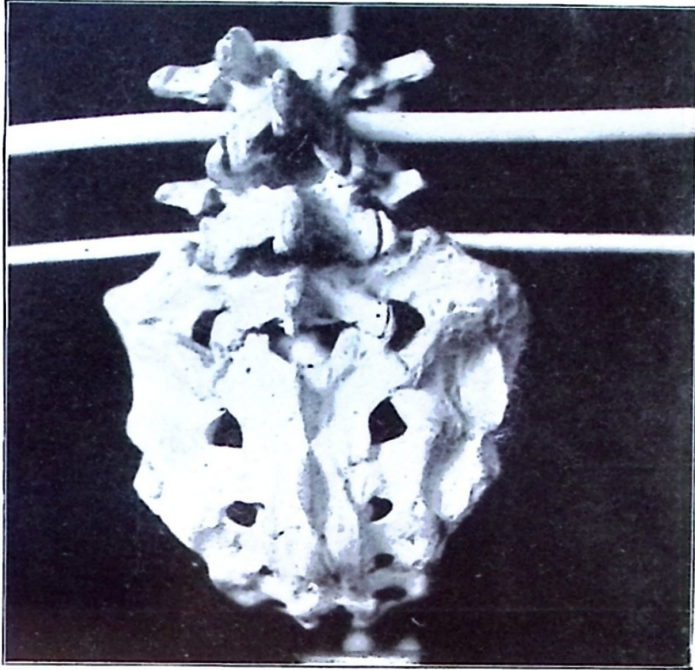


Fig. 441

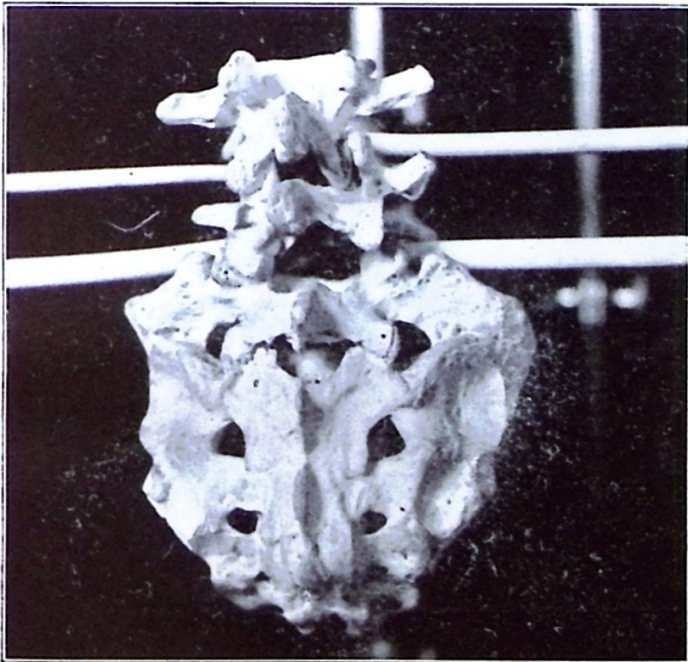


Fig. 442



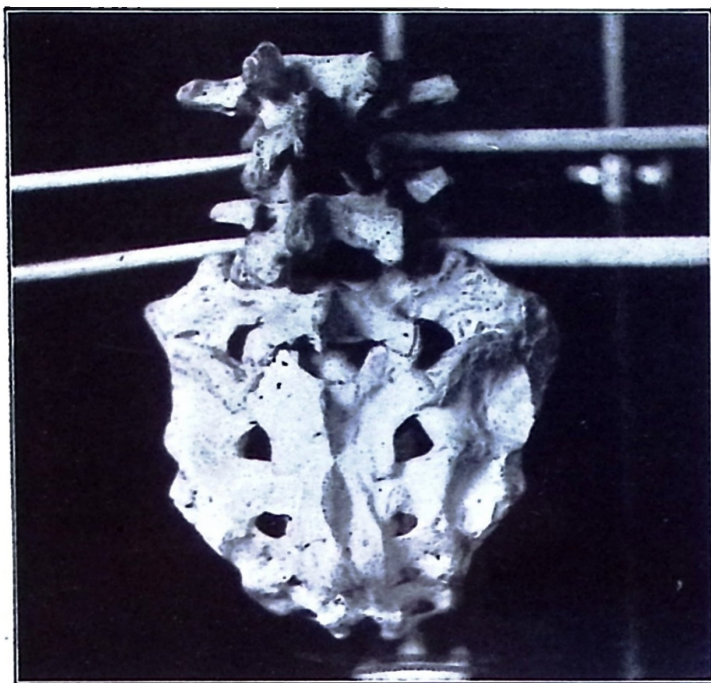


Fig. 443

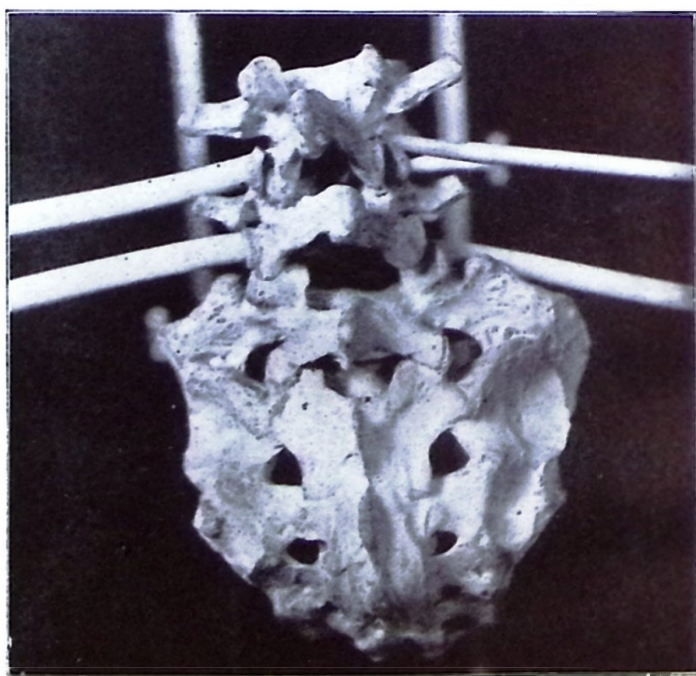


Fig. 444

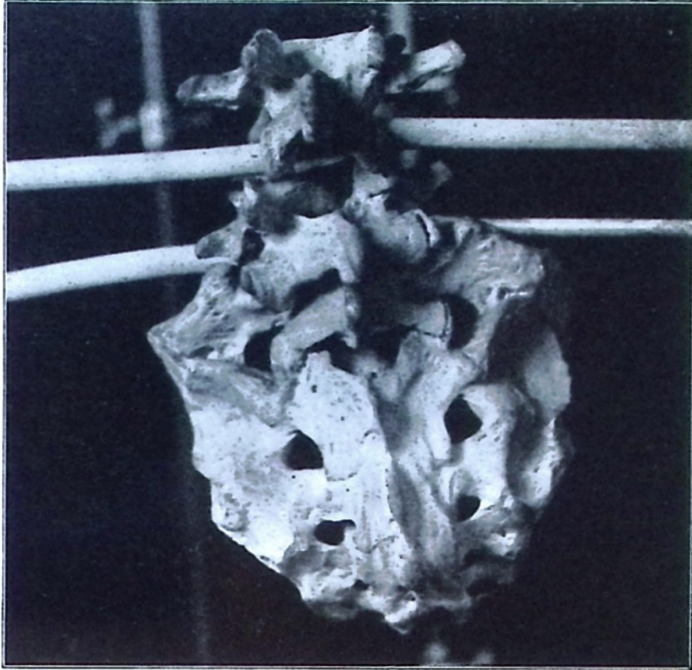


Fig. 445



Fig. 446

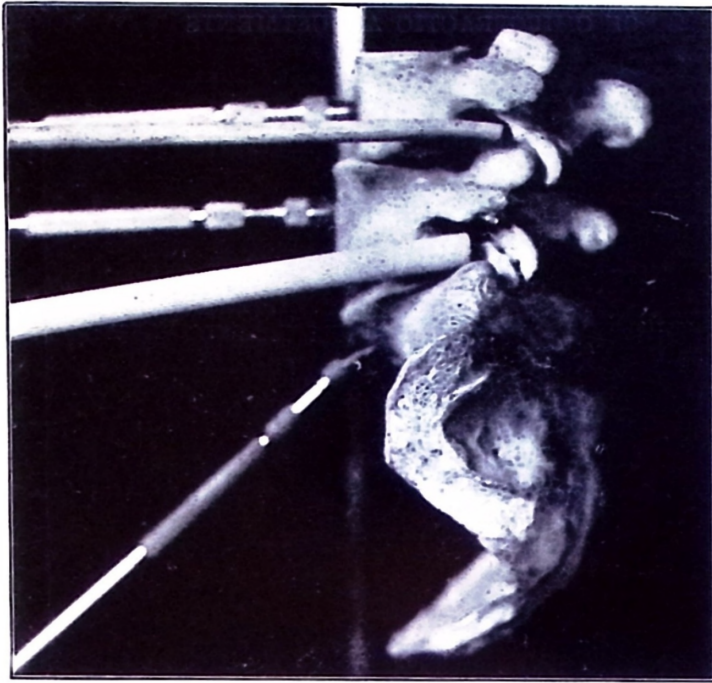


Fig. 447.

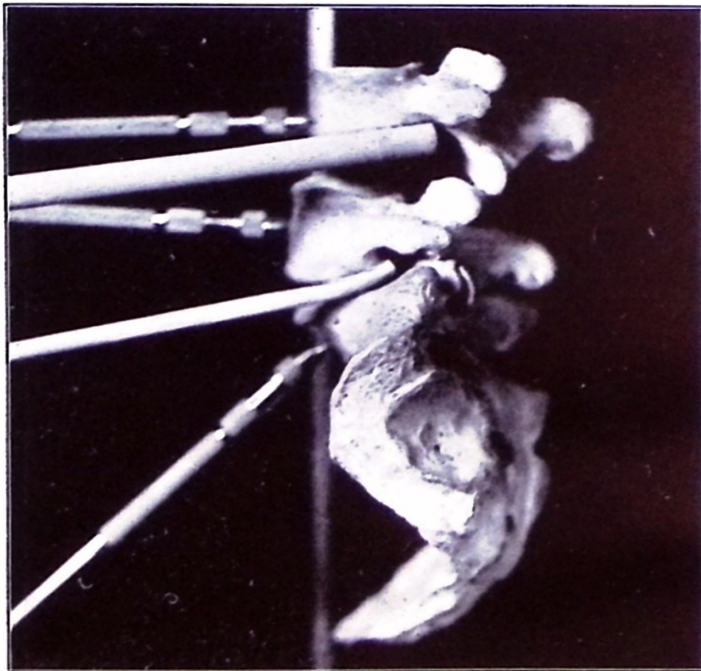


Fig. 448



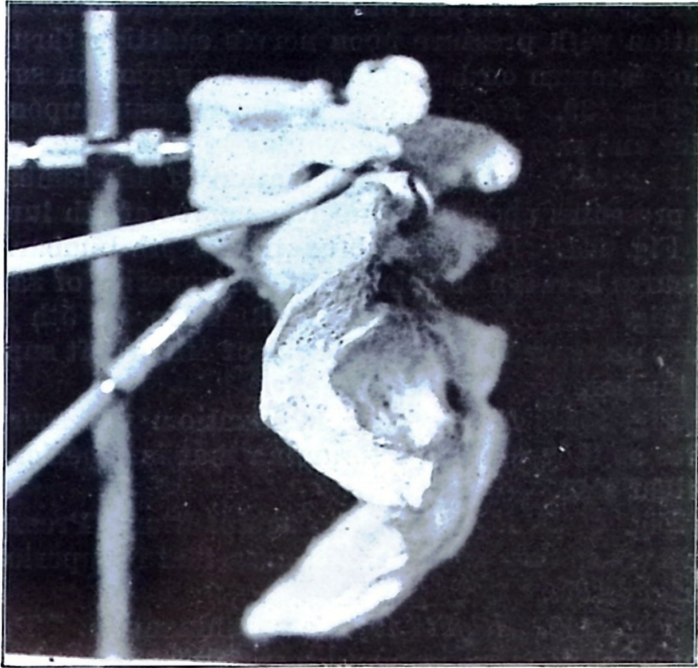


Fig. 449

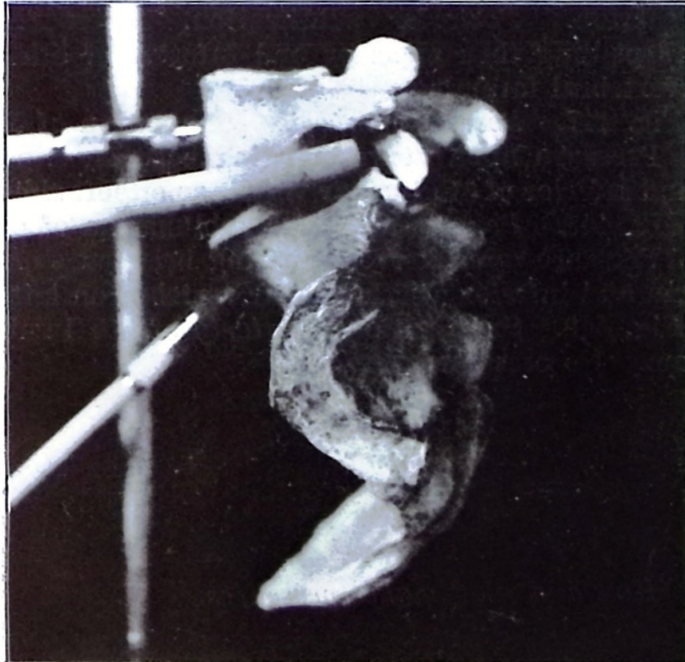


Fig. 450

Fig. 437. 4th and 5th lumbar and sacrum. 4 normal nerves.

Fig. 438. 4th and 5th lumbar and sacrum. Left subluxation with pressure upon nerves emitting thru 5th superior foramen on left and sacrum superior on same side.

Fig. 439. *Right* subluxation. Pressure upon 5th superior and sacrum superior nerves on right side.

Fig. 440. *Superior* subluxation of 5th lumbar. Notice pressures upon both superior nerves of 5th lumbar.

Fig. 441. *Inferior* subluxation of 5th lumbar. Notice pressures between inferior of 5th or superior of sacrum.

Fig. 442. *Left superior* subluxation of 5th lumbar. Notice pressure upon left inferior of 4th or left superior of 5th lumbar.

Fig. 443. *Left inferior* subluxation. Pressures upon nerves as they pass thru foramina that is superior to fifth on right side.

Fig. 444. *Right superior* subluxation. Pressures upon nerves as they pass thru foramen that is superior to 5th on right side.

Fig. 445. *Right inferior* subluxation. Pressures upon nerves as they emanate thru foramen that is inferior to 5th lumbar, on right side.

Fig. 446. *Left lateral view* of 4th and 5th lumbar and sacrum. *Posterior* subluxation. Pressures upon nerves passing thru superior and inferior of 5th lumbar intervertebral foramina.

Fig. 447. *Posterior superior* subluxation of 5th lumbar. Pressure upon nerve emitting between superior of 5th and inferior of 4th lumbar vertebrae on left side.

Fig. 448. *Posterior inferior* subluxation of 5th lumbar. Pressure upon nerves emitting between superior of sacrum and inferior of 5th lumbar vertebra on left side.

Fig. 449. Subluxation *inferiorly* of 5th lumbar versus sacrum. No pressures.

The pressures upon nerves that would take place in the above exist between the 5th lumbar and sacrum by the occlusion of the sacro vertebral, intervertebral foramina which would consequently create pressure upon nerves.

8. *Functions and organs involved.*

The organs involved (and by the use of this term "organs" I mean tissues as well as viscera,) would be located in the pelvic girdle, the viscera contained therein and the buttocks including the limbs, owing entirely to what functional fibres are distributed from these foramina, inasmuch as no two people are alike in that respect. Altho it can definitely be stated as to the region involved.

9. *Adjustments necessary to correct each.*



Fig. 451



Fig. 452



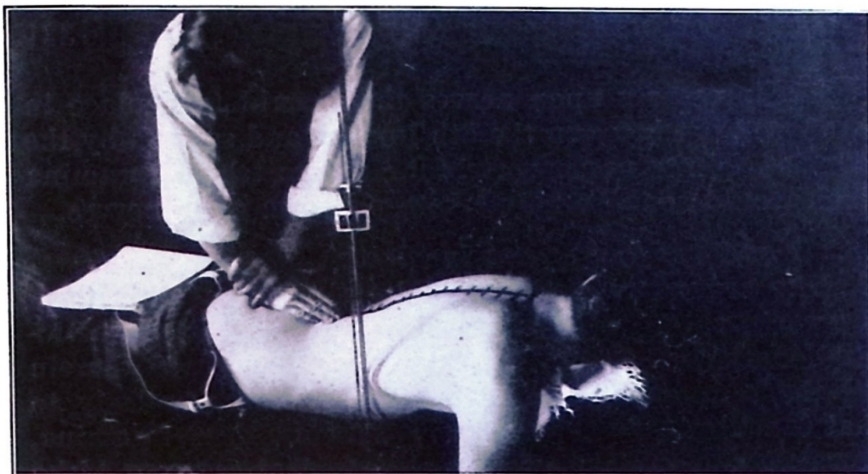


Fig. 453



Fig. 454



Fig. 455

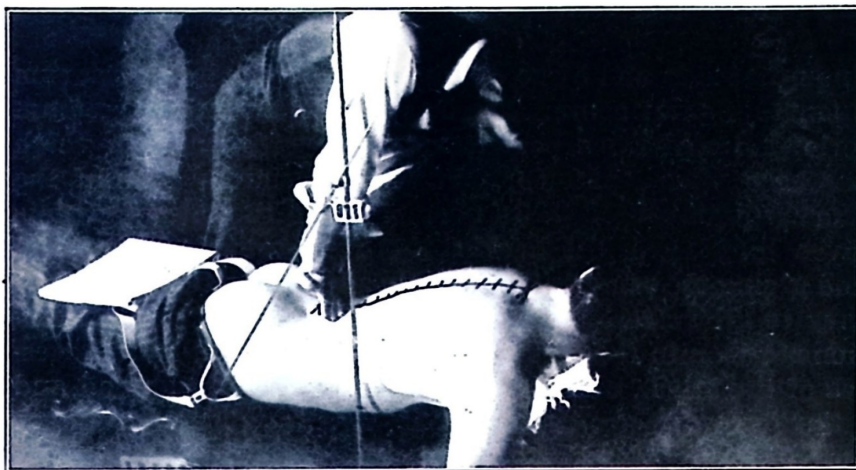


Fig. 456

Fig. 451. Hands in position adjusting a *posterior* subluxation of superior portion of sacrum.

Fig. 452. Adjusting *inferior* to decrease the abnormal enlarged sacro-vertebral angle.

Fig. 453. Right one half of sacrum is *posterior* to its normal position. Adjustment shows right hand as the nail hand and left as the hammer hand. Hands are placed on right lateral, superior posterior portion and adjustment given *anterior*.

Fig. 454. The left half is *posterior* of median plane. The adjustment is the same only sides and hands are reversed.

Fig. 455. Right half is *superior*. Adjust *inferior* and *anterior* upon that side.

Fig. 456. How to adjust left side when *superior* to a horizontal line.

The adjustments necessary are based primarily around the same principles as previously advanced only the application is different. If the right half of the base be superior to a transverse horizontal line, the heel of the hand should be directed upon that side and force be given to inferior. If the left side be the superior then the opposite conditions apply. If the left lateral half be posterior of the median perpendicular plumb line, according to primary and secondary curves, the adjustment is given

upon that side and by so doing you work the entire sacrum upon this axial center which revolves, thus the right anterior half reaches a posterior normal with its mate which has been placed anterior. If the superior or base of the sacrum is posterior to its normal curve the adjustment is given by placing the heel of the hand upon that portion and giving the same quick forcible adjustment that is necessary to all vertebrae to get the responsive returned functions. When in the last named position the spinous processes of the 5th L. and 1st S. will be found to be spread and the centra are compressed. By the above movement you will return them to a normal equality so that a line drawn horizontally from anterior to posterior would be on a level.

Occasionally it will be found that there is an anterior condition of the 5th lumbar in connection with the same of the sacrum. This subluxation, anatomically proves the opposite of the above, viz:—approximation of the spinous process and diastasis of the centra. To equalize this abnormality adjust the lower  $\frac{1}{2}$  of the sacrum to the anterior, making of that a fulcrum to raise the superior  $\frac{1}{2}$ . The bearing or stationary base of the fulcrum would be upon the articular surfaces. Care must be used in this later movement as the base of the sacrum when subluxated anteriorly is a difficult one to raise and if too great a force be used on the inferior portion, the liability of fracture might be great, especially in youth.

10. *How to give adjustments correctly.*
11. *What means, and portions thereof, to use.*
12. *What diseases to adjust Sacrum for.*

The diseases that occur from this locality, I am pleased to state, are rare. Many an unexperienced Chiropractor might have occasion to believe that such was the cause of pain in the hips or over that organ itself. Many a subluxation exists in the lumbar and pains or osteitis of these lower localities are traceable to the lumbar thus proving that while the effects are in and surrounding the sacrum, the cause is higher.

The names of diseases following these subluxations are characteristic of what occurs in the lower lumbar.



Very rarely a fracture of some one or more of the sacral vertebrae may take place in youth and produce consequent pressures upon nerves and create a permanent disease. These are exceedingly rare and in the history of this school only one case has been met where that condition was attributable.

CHAPTER 27.  
COCCYX.

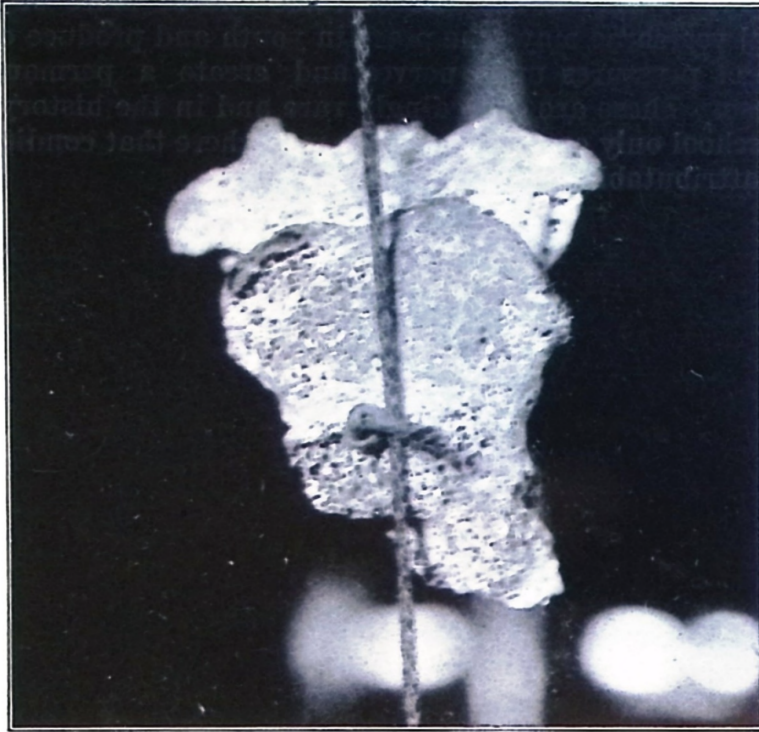


Fig. 457. The Coccyx.

1. *Vertebra and its title. Cc. P.*
2. *Superficial palpation and landmarks.*



Fig. 458

Fig. 458. Location of the coccyx under palpation. Study its position, whether too far anterior, posterior, left or right.

This is the vestigial remnant of man's progenitors and as a caudal appendage is, as time progresses, gradually being withdrawn from future generations. Past observations are in accordance with such ideas as are demonstrated particularly in the Comparative Osteological Dept. of the Smithsonian Institute, Washington, D. C.

This portion of the spinal column is deeply imbedded in the recesses formed by the proximation of the buttocks and in accordance with the primary and secondary curves of the spinal column is curved obliquely forward, inward and usually slightly upward.

3. *Normal position and articulations.*

Its usual position is easy to determine by palpation. It should, in the normal, follow the same degree of curve as is made by the sacrum, gradually extending around that portion or arc of a circle determined according to length. This varies in all individuals, altho the study of this particular segment as elucidated in *The P. S. C. Osteological studio* shows the normal has, averaging, three vertebrae. In these respects I am a believer in the Darwinian evolution of man.

4. *Subluxation described and illustrated.*



Fig 459



Subluxations or properly speaking abnormal positions of this portion are very common so much so that very little attention need be given it when located. It would be rare to find a person who has not, at some time or other had a severe fall and forced the coccyx inward and upward, making more or less of a sacro-coccygeal right angular articulation even to forming a new articulatory surface of the 5th of Sacrum to accommodate it.

6. *Where nerves are impinged.*

Anatomy teaches that there is one pair of nerves emitting between the last sacral and first coccygeal thru the cornua of each, forming an intervertebral foramina which is so large comparatively and which so many people are minus is the accounting for the few cases where a disease can be accounted for by subluxation at this point.

7. *How and what makes pressures.*

8. *Functions and organs involved. Location of—*

Twelve years of experience, based upon Chiropractic knowledge of the best and broadest has elicited only a few cases where an adjustment here permanently corrected the cause of the disease.

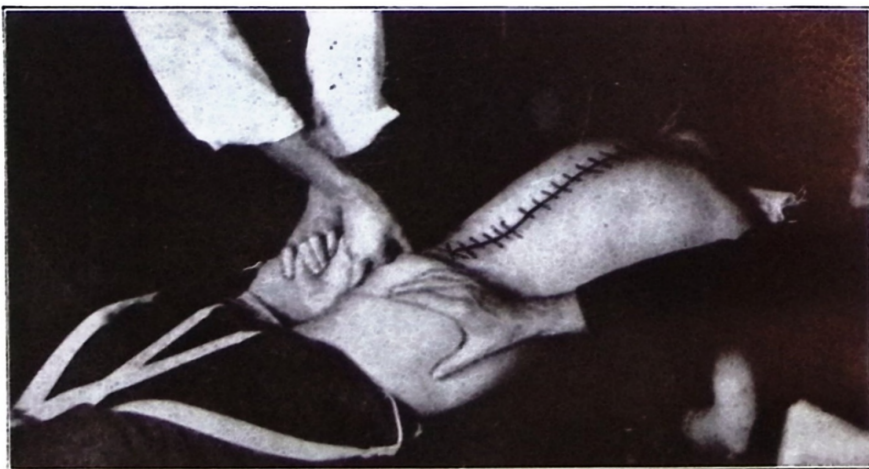


Fig. 460. Showing patient prone with adjuster's finger under tip of coccyx. The same kind of quick movement is used here as elsewhere established thruout this volume.

The case in question had sharp stinging, burning pains in the region thereto. Palpation showed great angularity and exceedingly tender around. Nerve tracing developed nothing further superiorly.

Adjustment was made by taking first finger, reaching thru rectum and catching under the bend, a quick pull outward and downward made it snap and the patients are quickly relieved and after one or two weeks of adjustments are well.

**THREE P. S. C. COURSES.****Arranged to Help the Busy Man or the One Lacking Finance.**

An increasing demand, from students wanting to learn Chiropractic, are so situated, financially and lack of time, that all could not be spent at one interval, has called for the full course to be divided to make it within reach. To comply therewith The P. S. C. will, on June 1, 1907, put into permanent effect the schedule below.

The P. S. C. has one standard (a nine months' course) from which it will not deviate, but the divisional character makes it a possibility for many to study that could or would not give it serious consideration, or if they did would matriculate at some struggling school offering all kinds of impossible inducements and sooner or later get discouraged and give it up disgusted, in preference to getting the best at more cost of time and cash. To overcome these features is the object of this statement. Many want to and can put in three months now and could spend three months later and then at some future date finish the balance.

Many persons cannot see their way clear to matriculate, pay tuition, board and room and buy books and a spinal column for nine months continuously, but could pay tuition, board and room for three months, then, learning some practical work in palpation and adjusting, enter the field, save the profits of that labor and return in three to six months, take another three months, returning the second time and then accomplishing the third course, completing and receiving the diploma. The payment of tuition (\$100) for Course 1 entitles the student to Courses 2 and 3. This dissection is no small item to prospective students, although it doubles the work at the school.

The three months' special course for Osteopaths and Medical practitioners still remains the highest standard for them. Completion of this time and passing the examinations places the average liberal osteopath in good trim as a Chiropractor and entitles him to a P. S. C. diploma.

Upon completion of each course the student has a brief examination of the work reviewed, after the passage of which he is given a three months' **CERTIFICATE OF ATTENDANCE**, beautifully printed on linen paper, the original is 17x22 inches, from lithograph drawings, and is a work of art, finer and more beautiful than any other diploma (with one exception—The P. S. C.'s) either of which are ornaments to any practitioner's office. (See reduced fac simile of either.)

Returning to take the second three months, the first certificate is returned to the school and upon the finishing of the second course, the same certificate is given for a six months' course. Upon returning the third time, this will be taken up and a full-fledged "**CHIROPRACTIC'S FOUNTAIN HEAD**" diploma, conferring upon the holder the degree of "**D. C.**" is awarded the diplomat. The diploma is engraved from lithograph drawings, on genuine parchment (sheepskin) and printed in three colors.

The schedule of each course, briefly, is as follows:

**First Course, Tuition \$100.00.**

First Month—Principles, Studies, Clinical Work, Etc.

Second Month—Principles, Studies, Clinical Work, and Palpation, Etc.

Third Month—Principles, Studies, Clinical Work, Palpation, and Adjustments, Etc.

**CERTIFICATE OF ATTENDANCE** for three months is issued upon the completion of this course.

**Second Course. Tuition Is Paid.**

First Course certificate is taken up, the student is given credit for three months. Tuition is paid, providing he return within one year from time of completing former course.



**First Month—Principles, Studies, Clinical Work, Etc.**

**Second Month—Principles, Studies, Clinical Work, and Palpation, Etc.**

**Third Month—Principles, Studies, Clinical Work, Palpation, and Adjustments, Etc.**

If the student has and can afford to spend the balance, or six months instead of three, the following will be the arrangement of

**Courses 2 and 3 Combined:**

**First Two Months—Principles, Studies, Clinical Work, Etc.**

**Second Two Months—Principles, Studies, Clinical Work, and Palpation, Etc.**

**Third Two Months—Principles, Studies, Clinical Work, Palpation, and Adjustments, Etc.**

Or the last six months may be broken up as Course 1 and 2.

Upon the completion of this course he is given examination No. 2, covering the period of six months' work, passage of which entitles him to a **CERTIFICATE OF ATTENDANCE** covering six months, which is so stated and signed by the same signatures as a **P. S. C. diploma**.

**Third Course. Tuition Is Paid.**

**Certificate No. 2** is taken up and six months' time and credit given for previous work and standing.

**First Month—Principles, Studies, Clinical Work, Etc.**

**Second Month—Principles, Studies, Clinical Work, and Palpation, Etc.**

**Third Month—Principles, Studies, Clinical Work, Palpation, and Adjustments, Etc.**

If the student (a nine months' one) wishes to remain through and finish the entire course at one time, in preference to breaking it into divisions, his work may be mapped as follows:

**Nine Months' Course.**

**First Three Months—Principles, Studies, Clinical Work, Etc.**

**Second Three Months—Principles, Studies, Clinical Work, and Palpation, Etc.**

**Third Three Months—Principles, Studies, Clinical Work, Palpation, and Adjustments, Etc.**

Or the student may break it into Courses 1, 2 and 3 as outlined, but the preference should be for the straight course and last outlined. Time is more advantageously spent and the harvest of intelligence better. The student completing nine months at one time has only the final examinations to pass.

After the "**Nine Months' Course**," broken or complete, he is given the final examinations, upon completion of which he is presented with the full course **DIPLOMA**, genuine parchment, with faculty signatures. This diploma is one of the most expensive and artistic productions issued by any school and worthy of any position.

These courses are open for the entrance of students at any time. Work is so arranged that the student learns each day's lesson complete as he goes.

In the selection of a school the student must observe which advances the graduate's interests first; is for principle and must bear in mind the age, ability, qualifications, reputation and equipment of the institution where he wishes to learn.

The **P. S. C.** is, has been and always will be "**CHIROPRACTIC'S FOUNTAIN HEAD**." Has a larger attendance than all other try-to-be schools combined. There must be reasons for it.

The **P. S. C.** has the largest pathological and anomalous osteological collection of any school, college or university in the world. This aggregation is a necessity to properly teach and study Innate Intelligence, which is the power creator behind man. That is why every school attempting to teach Chiropractic has abnormal specimens, but The **P. S. C.**



**The Palmer School of Chiropractic**  
 INCORPORATED  
**DAVENPORT, IOWA, U.S.A.**  
 THE PALMER SCHOOL OF CHIROPRACTIC  
 D.D. PALMER, PRESIDENT

Be it Known, That \_\_\_\_\_

has completed \_\_\_\_\_ third of the course of study as taught in this "Chiropractic's Fountain Head" school, and passed the \_\_\_\_\_ grade examination in Anatomy, Physiology, Pathology, Diagnosis, Nerve Tracing, Chiropractic Orthopedy and the Principles, Theory and Practice of Chiropractic.

In testimony whereof we confer this

## Certificate of Attendance

this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_ and subscribe our names.

has been years collecting ahead of them. Other schools purchase what they can afford. The P. S. C. accepts the choice selections from direct importations. To study the creation without the creator is but to half realize what you are doing. To investigate intelligently means specimens are a necessity; the more you observe and have taught to you the keener and deeper is the insight of this collective study. To work with a mere half dozen specimens is but to barely border the field. Do you want cream or skimmed milk? The P. S. C. faculty are the original researchers; the discoverers and path blazers of past, present and will be for future Chiropractic work. Will you have the scientific or crude adjuncts with a pinch of Chiropractic for seasoning?

**A CERTIFICATE OF ATTENDANCE** or a **DIPLOMA** from The P. S. C. is worth much more than a diploma from any other school, regardless of time spent, because the work covered and accomplished but portrays the extensive and unlimited Chiropractic knowledge and capabilities of the student manifoldly multiplied. The P. S. C.'s graduates' ability to deliver results and prestige is what will determine his success. Look over the field, where are the Chiropractors with large practices? What school do they represent? The answer invariably is "I am a P. S. C. Man From the Parent School."

**THE CHIROPRACTOR** (The P. S. C. monthly journal, 50 cents per year) advances the public interests of that graduate, for hardly an issue appears but what they are given free clinical notices. This item alone, from the only Chiropractic journal published, is worth hundreds of dollars. The P. S. C. has endless correspondence with every state in the Union, each person getting subsequent copies, thus placing a local Chiropractor's name before them. Inquiries from that state are promptly forwarded to that graduate. This is a feature no other school can do.

The P. S. C. is headquarters for all that is Chiropractic, in the way of education, latest practical ideas, past experiences, old adjustments now relegated to the rear for better, the latest in discoveries thus representing the culmination and accumulations of Chiropractic ideas from its discovery 12 years ago to its present date. It was the first school to teach Chiropractic; to graduate students; issue Chiropractic diplomas; place books upon the market that are authentic and reliable containing simplified, classified knowledge, and not full of juggling words that are not understood. It is the only school that issues phonographic lectures for use in home, office or lecture hall, and supplies the market with adjusting tables, solid or folding, etc. In fact, where do all innovations come from that are characteristically **CHIROPRACTIC**? What school is it that prints over 100 different folders, from electroplates at cost, for its graduates to advertise with? The answer to all is "The P. S. C."

The P. S. C. is the only school that will not teach, mix with, or countenance anything outside of specific, pure, unadulterated, philosophical Chiropractic. It does not teach, advise or use adjuncts of endless torturing or of no result giving character. It is the only faculty that have Chiropractic so thoroughly studied that can teach, use and prove, anatomically, physiologically, philosophically and scientifically the superior efficacy of Chiropractic minus adjunctive crutches. These are but a sample of reasons of what all past P. S. C. students have proven to themselves before matriculating. The opportunity to prove them to you would be our pleasure. Investigation will prove all these and then some.

Correspondence will be cheerfully answered but must be addressed to

**B. J. Palmer, D. C., Pres. and Sec., The Palmer School of Chiropractic,  
"CHIROPRACTIC'S FOUNTAIN HEAD," Davenport, Iowa, U. S. A.**



## \$100 TUITION INCLUDES MAN AND WIFE.

Suppose the husband matriculates at *The P. S. C.* and the wife attends to her home. When evening comes he attempts to explain the day's work; how the clinics were conducted, what the diseases were; where each was adjusted and why. He even *tries* to show *how* the work is done. This is perfectly proper, and has been repeatedly done in the past; is going on now and will continue to be so, for as the interest of the one increases so does it in both. As soon as the husband realizes the value of adjustments, he then wants his wife to be able to adjust him and perhaps "a few cases that would prefer her to him." It is not long until her hand is broken into the business, *as best she can*, and according to the precepts is advanced second handed thru the husband.

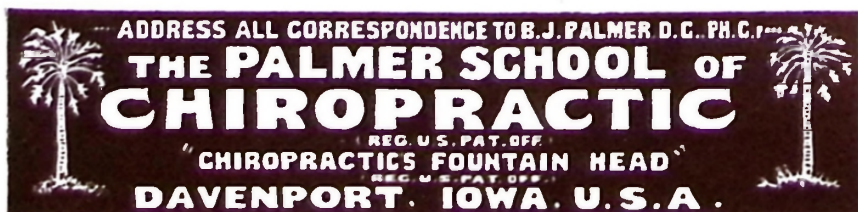
Perhaps the Dr. (when in practice) is called to some case out of the city and is gone several hours, days or a week, or, he has many outside calls in the city and is gone all forenoon and meanwhile one, three, five or ten patients have called at your office and been dismissed because "I did not feel confident to do anything." That much cash, in sight, has been lost. Why? *Because she was not a full fledged, capable Chiropractor.* Who's fault was it? Nobody's. Why? "Because we did not have the extra \$100 to put her thru." What *she* loses is that much out of his pocket. They are as one, therefore, sooner or later, he teaches her the essential part of the business as best his ability allows him.

The wife can make a business greater if she be posted on its philosophical details or break its very foundation if she be ignorant and does not understand *why* her husband does this, that or the other. that the patient wants light on but does not understand. The larger proportion of sick, in average practice, are women. To bring to their view the better way of *adjusting causes, where, what for and how*, in preference to treating effects by this, that or some other means, often involves itself upon the wife, while the husband is busy on some other case. The fact remains that some women wont have a man doctor—the woman D. C. can gain cases for *their* firm that he would lose.

Knowing the success of the one graduate depends upon unanimous action of both, we feel that it is an assistance to the husband to have the wife properly trained. The success of one means the success of both. The wife must know the work sooner or later, *and she had better learn it right, thus showing BETTER CREDIT UPON THE SCHOOL* they represent.

On January 1st, 1903, this rule will go into effect. The matriculation of either husband or wife permits the other the same rights and privileges. To further defray expenses in giving the second party a matriculation, second examination, time consumed in correcting papers, issuing the second diploma, etc., it is further required that each wife (or husband) shall contribute \$5.00.

We take it for granted that *both* parties are here *for business*; will profit thereby and appreciate the value of the work just as much as if it had cost the original single tuition.



## A UNIQUE FEATURE OF THE P. S. C.—OUR OSTEOLOGICAL STUDIO

A charming and unique feature of The P. S. C. is its osteological studio. It is something to be able to say, "this is the finest, largest, and best collection of human bones, in the world." It is this which makes our studies more interesting, our students more interested, and our graduates out-shine those of all other schools. To the casual visitor who spends a day amongst them, each specimen has a silent story, but to the student who is "drilled" in them daily for nine months they become as an open book—the outcome of deductive reasoning along the lines of Chiropractic Philosophy as taught at The P. S. C. Nowhere in the world can the study of pathological and anomolous bones be better accomplished, and in no school in the world is there teachers better equipped with knowledge of them, and better able to impart it, than at "Chiropractic's Fountain Head." We have hundreds of specimens of every bone in the human body, both normal and abnormal, thus allowing comparison, with scientific reasoning, to beautify and render interesting the study of them. A day in the studio is well spent—it is an opportunity—a privilege, nowhere else met with—and we extend it to all who desire to enjoy it. The work of Innate Intelligence, under pathological, traumatic and normal conditions, can be deeply and profitably studied. To the initiated student, studying—we will say—vertebrae it is easy to see at a glance why one person is restored to health by one adjustment, while another may take weeks or months. You must see, and have explained to you these things, before you can fully understand them. Ankylosed, carious and wedge shaped vertebrae; conditions of necrosis, osteomalacia, osteosclerosis, osteospongiosis, osteophyma, exostosis, etc., etc., by the thousands are all represented. Femora, radii, ulnae and long bones generally are exhibited in various forms of fracture. Knit during life by Innate Intelligence; refractured and re-knit by the same agency; bones which in life have been faultily set—all have their histories, written in large letters, for the thinker. Many articulated skeletons, exhibiting conditions of gibbosity, lordosis, scoliosis; fractured ribs, vertebrae or limbs; sequestra, parts atrophied or hypertrophied, necrosed, etc., etc. Giant fetal skeletons, skulls, pelvic girdles and extremities; in fact nothing is lacking. In one word it is complete; something never to be forgotten. Expense has not been considered in getting together this magnificent collection. It is one of the wonders of the world; here for you, and you ought to see it. Don't rest until you have made this possible. The only complete collection at the only equipped Chiropractic School is open for you to see. It's an immense opportunity. Grasp it! You'll benefit.

Read Mr. Charles Truax's opinion (of Traux, Green & Co., Chicago).

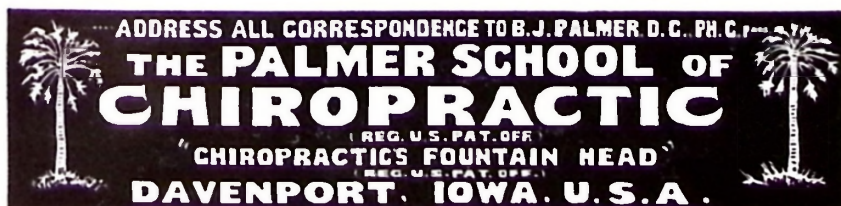
"Dear Dr. Palmer:

"I wish to express my thanks for the privilege of looking over and making an examination of your collection of pathological and anomolous bones.

"It is certainly a fine assortment and is by far a much larger collection than can be found in any other part of the United States and I doubt if, in many respects, it can be excelled anywhere. It was certainly a great privilege—one that I fully appreciated.

"Again thanking you

"Yours very truly, CHARLES TRUAX."



## CONSULTATION AND EXAMINATION AT THE P. S. C.

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Consultation free. Adjustments at The P. S. C. \$10.00 for the first and \$5.00 each week thereafter. This includes all cases except lupus, cancers, tumors, and epilepsy, which are \$20.00 the first and \$10.00 each consecutive week. Room \$1.50 additional each week.

Adjustments and reservations must be paid each week in advance.

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## OUT OF TOWN CALLS

B. J. Palmer, D. C., answers all calls from a distance where immediate and experienced results are imperative. Distance is immaterial. Acute diseases are the object of the majority of calls but many chronic, contemplating adjustments at The P. S. C. often prefer a visit of Dr. Palmer, previously, to make certain that results can be manifested before assuming the responsibilities of such a trip.

Dr. Palmer is subject to immediate call, at any hour, day or night, (providing he is not out on some other trip or not previously engaged for that day.)

Write or wire and reply will be promptly made, by telegram or letter, stating just what hours and day of arrival can be depended upon.

One night \$10.00 and expenses.

Sunday and nights, coming or going, \$25.00 and expenses.

Week days, night included, \$50.00 and expenses.

Time is computed from hour of leaving school.

The P. S. C. is glad to furnish complete itineraries to anyone coming or leaving Davenport.

Make telegrams or letters explicit and brief.





## Ph. C.--Philosopher of Chiropractic.

"Philosophy has been defined: The science of things divine and human, and the causes in which they are contained;—the science of effects by their cause;—the science of things evidently deduced from first principles;—the science of truths sensible and abstract;—the application of reason to its legitimate objects;—the science of the original form of the ego, or mental self;—science of the absolute;—the science of the absolute indifference of the ideal and real."—*Sir W. Hamilton in Webster.*

"Philosopher;—One who philosophizes, one versed in, or devoted to philosophy." 2.—"One who reduces the principles of philosophy to practice in the conduct of life; one who lives according to the rules of practical wisdom."—*Webster.*

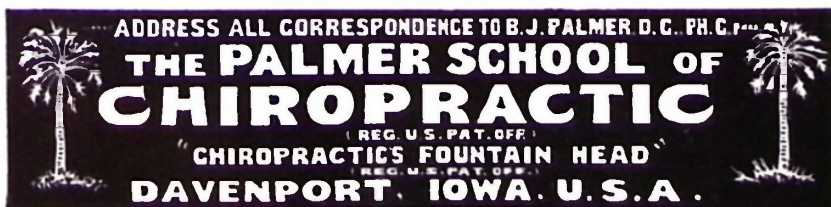
The philosophy of Chiropractic, as taught exclusively at *The P. S. C.*, embraces all of the above definitions and comes within their bounds and limits. Knowing this—this school will, after January 1st, '08, issue to each student having an average of 98 per cent or over on final examinations, at the expiration of his three or nine months course (according as he is an M. D., D. O., or a layman) a diploma conferring the degree of "Ph. C." (Philosopher of Chiropractic). If below that standard, then the usual "D. C." (Doctor of Chiropractic) will be granted.

All students completing a "P. G." (Post-Graduate) course of three months (without charge other than tuition of \$100, paid at the time of first matriculation), and passing an advanced philosophical examination with an average of 90 per cent or over, will have the degree of "Ph. C." conferred upon them. To defray the expenses in giving the graduate a *second* examination, correcting papers, issuing diploma, etc., it is further required that each post-graduate candidate for the "Ph.C." shall contribute \$5.

Either of these diplomas will be the same as the ones now issued, given gratuitously, with the exception of the degree, which will be printed to correspond. This gives the "P. G." two diplomas, each with a different degree.

The high percentage in first examinations acts as an incentive to reach a higher degree of efficiency, bringing forth the best efforts of the student.

Any graduate of *The P. S. C.* is entitled to return at any time and get the advanced thoughts and work, without extra charge. If he wishes the examinations and, upon their completion, wishes the advanced degree, the above regulations must be complied with. *The P. S. C.* diplomas are genuine parchment, 17 x 22 inches, made from lithograph drawings printed in colors, are not for sale at any price but must be earned.



# NIGHT SCHOOL

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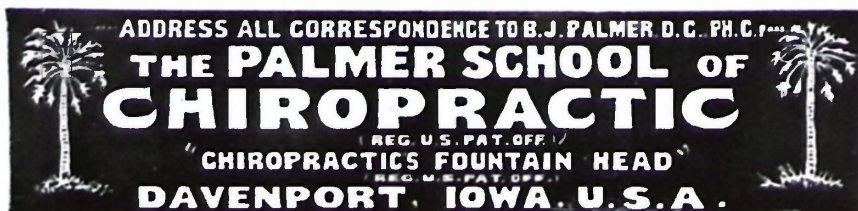
*The P. S. C.* has had many inquiries for a *night school* in Chiropractic. Many men wishing to be Chiropractors, who could and would pay tuition of \$100 at time of matriculation, are hindered by lack of living expenses for themselves or family while attending school. To make this science a possibility, *The P. S. C.* has inaugurated a system of three nights per week, Monday, Wednesday, Friday.

By this arrangement each student can put in days or Saturdays and evenings, following the pursuit of his vocation. Davenport has all kinds of factories, shops, or clerical work, enabling him to make a living *and* study Chiropractic at "CHIROPRACTIC'S FOUNTAIN HEAD." The time to complete this course will be longer, but he can get knowledge without risk of finance. It is better to attend day school if possible; if not, do the next best.

The night student can, at any time, attend day lessons or change to the day work, or the day student can shift to night work, at any time during his course, without extra charge. Credit will always be given, on his full course, for the work of the other.

The Night School man has every advantage extended to him that is granted the day man. The outlook for the night class school far exceeds any previous day school matriculation that *The P. S. C.* has had. *Now* is the time to arrange your home duties and work to get foot loose. Bring your families and *come direct to The P. S. C.*, where a full list of rooming and boarding houses of all prices are kept on file and will be furnished upon your arrival.

Correspondence regarding this night class cheerfully answered.



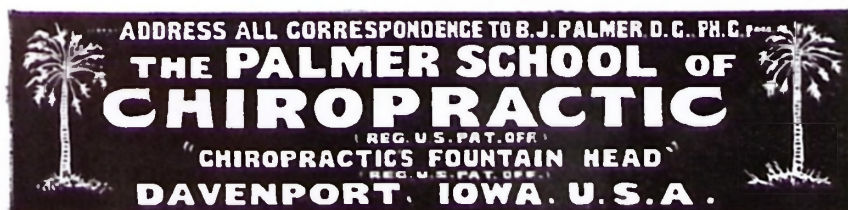
## Stereopticon Lectures.

In addition to the 24 lectures on diseases to be delivered this winter, B. J. Palmer, D. C., Ph. C., will discourse on 52 lessons, illustrating—

- 1st.—Each vertebra in the spine.
- 2d.—How to palpate for normal and abnormal positions.
- 3d.—Illustrations showing each and every subluxation that is possible and does exist between vertebrae.
- 4th.—Pictorially depicting the foramina where pressures upon nerves exist with each subluxation formerly shown.
- 5th.—Following this set, views are shown how to adjust each vertebra and how it would release such pressures.

Each vertebra is in two lectures and involves between 50 and 75 views. *The P. S. C.* has spent a great deal to introduce this practical feature, but its extreme value can be grasped in a moment. Upon this knowledge is based Chiropractic philosophy, science and art. The first lecture will be delivered immediately following the holidays. If you are contemplating the study of Chiropractic at *The P. S. C.*, arrange to come right now and take this in.

One each Monday and Friday afternoons from 4 to 5 at the class room. These lectures are free to day and night students alike. Over 4200 views have been taken for this express purpose. Think it over and act now.





**The 1906 Enrollment was Large.**

**The 1907 Enrollment was Larger.**

**You Can't Do Better than Come NOW  
and Make the 1908 Classes the  
LARGEST.**

**HERE'S THE POINT!** We're on the track of a fortune for you. There's money in every spadeful of P. S. C. Chiropractic. All you need do is turn it over from the School to the people. They're ready, and will pay for it gladly, and recommend others to do likewise. **WHY?** Because if you take The P. S. C. course you will be able to "deliver the goods." That's the one and only thing that counts. Not only dollars, but thanks and gratitude await our graduates. Deeper than all this is the inward pleasure of being instrumental in relieving humanity of pain and suffering. What higher and nobler work is there in life? What better and more inspiring motive to join the ranks of The P. S. C.? Already our Science and Philosophy are world-wide. The sun never sets on our graduates or our work.

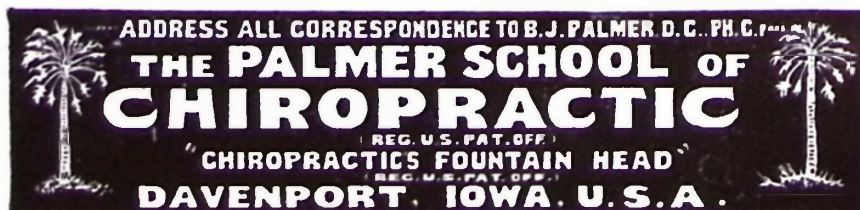
**FIGURE IT UP!** Remember, it's the early man gets the full tray. It does not take a lot of time and energy to give adjustments, nor a lot of worry to make a cart-load of dollars. P. S. C. training is all that's necessary—success follows surely.

**QUIT DRIFTING!** Relax your hold on doubts and cares. **ACT, ENROLL!** We can do the rest. Once you see our goods you won't rest till you're selling them. No drifting then, but just one fixed definite aim—relieving human suffering and diffusing universal happiness. If you know of anything better, anything higher, take it and let us know of it. A good income is assured to The P. S. C. graduate. **Why?** Because he has what the world wants. His patients get value. They bring others, and so save advertising bills. The goods advertise themselves. The P. S. C. helps its graduate in the field by heading patients towards him. Everything is in his favor! Fortune no longer frowns, but **KEEPS SMILING**, in company with his ever-increasing army of ever-improving patients.

**THINK OF IT!** Would you be President or a Chiropractor?

**NO LIFE LIKE IT!** is said and acted by all our representatives in the field.

Somebody is going to get a harvest in your town. There are lots of "incurables(?)." Hurry up or someone else will get the crop. The harvest will be dollars, thanks, and smiles—all acceptable. Wake up and get busy! **NOW'S** the opportunity. \$100 pays your tuition for nine month's instruction, comprising 1332 solid hours of personal, face to face instruction. You are in contact with the "men who set the pace," and the best and most competent teachers of pure, specific, unadulterated, philosophical Chiropractic. You are also in company with students from all parts of the world. We have the best and largest anomalous and pathological osteological collection in the world, also more than 4200 lantern slides, showing all parts of the anatomical structures of the body, normal and abnormal. Lectures are delivered from these three nights per week. The P. S. C. shows you the goods—makes you competent and confident. Don't waste time; it's money. Think seriously! **ACT PROMPTLY**—go for all you're worth and **WIN**.



READ ALONG CHIROPRACTIC LINES! EDUCATE YOURSELF  
CHIROPRACTICALLY!

## The "Science of Chiropractic," Vol. I.

is the book for you. Colaborated by and containing many of the best ideas of B. J. Palmer, D. C., Ph. C., President of The Palmer School of Chiropractic. Every seeker for light should have this book. It's 400 pages and 102 illustrations, explain in an intelligible way, this new and glorious Science which is so rapidly superceding osteopathy and other systems—manipulative or otherwise—which treat effects. The cause of disease—inco-ordination between Innate Intelligence and her physical medium, the human body—is explained with clear and lucid detail. How the skilled chiropractor adjusts the subluxated vertebra or vertebrae which interfere with normal transmission of mental impulses, from brain, along nerves, to point of expression—tissue cell, is what this book aims to teach. It proves that lack of these life-giving mental impulses, or excess of them, means inco-ordination or disease. This condition is produced by subluxation of vertebrae, resultant from a concussion of forces which are unequal. It gets right to the rock-bottom; we can't explain all here; sufficient to say every osteopath, M. D., or practitioner of any school ought to have this book and study it. If the world's "healers" only knew what they were missing, this edition would be swamped. The half-tones of specimens—normal and abnormal, position of operator and patient—position of hands in adjusting vertebrae, photographs of students of The P. S. C. at work, class work, dissecting, etc., etc., are all interesting and help wonderfully in the study of this excellent volume. It gives you some idea of what goes on at "Headquarters," Davenport, Iowa. It teaches you how to save work and time, how to work on definite scientific lines with one end always in view. It explains the Science which gets the longed-for results. It is the first chiropractic work on the market, and does not spend a page on the discussion of adjuncts of any kind. Its ideas, like the School from which it emanates, is "exclusive." No book has before attracted such attention or been discussed so much in medical circles; the arguments put forth are unanswerable—it teaches truth. Wherever it goes, medical and osteopathic superstition is dispersed. No "feeling in the dark" to the chiropractor; no "perplexed" or assumed "wise" look for his patient to see and admire. "Straight to the cause" (and he always finds it) is his motto. Why wonder at his success under these circumstances? Why wonder that your neighbor, who knows only a little of chiropractic, gets all the business. Perhaps he has Vol. I of "Science of Chiropractic", you haven't. See the cause? Adjust it by sending in your order for a copy. Co-ordination will thus be restored and patients will again come your way. We wish we could say more about it and "set you longing," but, get it and see.

Complete copy—handsomely bound in cloth, price \$3.35, postpaid.





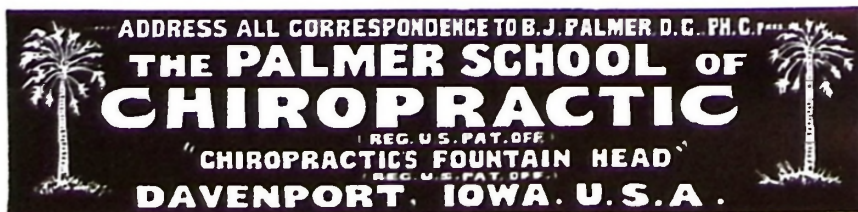
**MORE CHIROPRACTIC! MORE TRUTH! MORE LIGHT!**

## Vol. II "Science of Chiropractic"

It gives satisfaction to Dr. B. J. Palmer to know that his lectures as well as his other work, will "live after him." At the request of numerous students and members of the various audiences, The P. S. C. has consented to place into book form the series of lectures delivered by "the young doctor," at The P. S. C. Lecture Hall, February and March '07. To people who missed the opportunity of hearing these lectures this book is just "it." Those who heard them were not content until they had them in their libraries, and they're the folks to judge. Many hitherto "hidden" truths are brought into the light and many open falsehoods are exposed. Daringly and fearlessly were the subjects handled by the lecturer, sparing nothing that was false and withholding no part of the truth. New ideas regarding the embryonic stage of life, forcible arguments against orthodox teaching with regard to the "sympathetic nervous system" and "reflex action" replacing this disproven theory with facts, proven beyond question, on the living subject. Dr. B. J. Palmer's discovery of the complete, direct Cycle of Life and its forces, gives to man a philosophical completeness which unlocks the door of mystery and makes every known function, whether performed normally or abnormally, clear as daylight. If a student was taught nothing but the spinal column, the brain and nervous system and their functions chiropractically, he would be better equipped to benefit suffering humanity than a graduate of the best medical school. This is no idle statement but is proven daily. Possession of this volume of lectures gives one a splendid chance to study all the important details of Chiropractic Philosophy. "Serous Circulation" another one of the many discoveries of Dr. B. J. Palmer, is ably presented. Many diseased conditions hitherto mysterious and unexplainable, can be readily understood and explained, by a knowledge of this important branch of chiropractic physiology. It tears down and suitably replaces the "blood theory" of nutrition. Investigators have tried to prove it false, but in the effort, the truth of it is revealed to them, and they are converted to it. The book makes friends, that is why we want you to have it, and have put the price low. It contains some of the cream of chiropractic truths and is complete in every detail. Don't let yourself rest until you have this, and Volume I and III. You might just as well order now and take advantage of the special offer. Don't say "I wish I had" but "I'm going to," and go.

Vol. II is the most talked of non-therapeutical book of the age.

Price—complete copy, postpaid, \$1.15.





## Vaccination—Are You Interested?

The P. S. C. has a book which you ought to read if you are worth 16 cents. "Vaccination, the world's greatest humbug" by Geo. W. Lawbaugh, is a book you can't afford to miss, and we have purchased 700 of them—at a discount, for the benefit of our readers. This little work is fit to grace any library, is printed on good paper and artistically bound in red cloth. Its price makes it "a sin to be without it." The author handles his subject well and fearlessly; he is a fighter for truth, justice and liberty, and his work is full of bare, startling facts destined to open the eyes of those fortunate enough to be able to read it. The P. S. C. is ever ready to help in such missions as this author has, and wishes to further so noble and righteous a cause. We want you all to read this book, and have put it at such an easy price as to make it impossible for you to resist. If you want sound advice, knowledge of actual unvarnished facts, and the outspoken truth concerning this abominable, filthy, ignorant practice of M. D's, don't delay, but send your 16c for this "little treasure." That vaccination is a crime has been taught by The P. S. C. since its birth. We want our readers to know it also, and as this work embodies our ideas on the subject, we could conceive no better and cheaper way of presenting them, besides adding a nice addition to your library. Let us have your order; we shall value it as much as a bigger one—our joy in seeing these books go out lies in the fact that we know that with every one goes a "ray of light" to dispel darkness and superstition. Children are saved from suffering—often their lives are saved, through the reading of such a book, by their parents.

After reading it you will never again allow filthy, loathsome vaccine virus to be injected into the body of your pure innocent child. Our heart-felt wish is that this book could be placed in every home; we feel sure that the "slaughter of the innocents" would then be stopped. The people would demand its abolition and with such a "voice of thunder" as would shake the practice to its foundations, striking the "learned ones" dumb.

Send us your order now—16 cents covers postage as well. You have our assurance, we know, you'll be "glad you did it."

Eight 2-cent stamps, or sixteen 1-cent stamps.



**SECURE CHIROPRACTIC PROPAGANDA FREE.**

The following articles will be given free for subscriptions to The Chiropractor, each of which must be for one year and 50 cents each. Every order must be accompanied with cash or its equivalent to cover entire list. Write names and addresses plainly. State article wanted, which will be carefully crated, packed or wrapped ready for shipment, and will be delivered in order of arrival. You will be notified, by postal, when the same will leave The P. S. C. If they do not arrive promptly, notify the undersigned.

Subs.	Selling price.		Vol- ume.	Title.
4	\$1.00	(Add. 15c post.)	2	"The Science of Chiropractic."
12	3.00	(Add. 35c post.)	1	"The Science of Chiropractic."
32	8.00	(Add. 50c post.)	3	"The Philosophy of Chiropractic."
40	10.00	(Frt. or exp. collect.)		Solid office adjusting tables. Oak base and detachable legs.
72	18.00	(Frt. or exp. collect.)		One complete suit case, ad- justing table. ....
60	15.00	(Frt. or exp. collect.)		Solid adjusting table, uphol- stered.

The following lectures, as contained in Vol. 2, are on 6-inch cylinders, ready for immediate reproduction.

Subs.	Selling price.		Cylin- ders.	Title.
6	\$1.50	(Frt. or exp. col.)	3	The Alimentary Tract.
6	1.50	(Frt. or exp. col.)	3	Functions.
8	2.00	(Frt. or exp. col.)	4	The Embryo.
8	2.00	(Frt. or exp. col.)	4	Reflex Action.
10	2.50	(Frt. or exp. col.)	5	Nervous System Chiropractically considered.
10	2.50	(Frt. or exp. col.)	5	The Senses.
12	3.00	(Frt. or exp. col.)	6	Disease, What It Is and Its Cause.
12	3.00	(Frt. or exp. col.)	6	Review.
14	3.50	(Frt. or exp. col.)	7	Sympathetic Nervous System.
34	8.50	(Frt. or exp. col.)	17	Circulations, Serous and Blood.

**Stationary Adjusting Bench.**

In addition to the suit case adjusting table listed at \$18, The P. S. C. also makes a stationary solid work bench, birch top, quarter-sawed oak, and base. Legs are detachable. The workmanship on these is excellent. Massive in appearance, they are strong and duplicate those in daily use at this school. These can be purchased for \$10 or 40 subscriptions to THE CHIROPRACTOR, The P. S. C.'s monthly journal, 50 cents per year, will get it free. Send all subscriptions, including draft, at one time. Table complete, crated for shipment, \$10. Upholstered with best plush and padding, \$15.

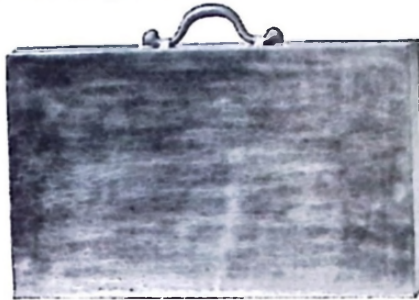
Every Chiropractor can, by a personal canvass among his patients, who are interested, secure the subscriptions and get one or all of these articles at no cost to him.



## SUIT CASE ADJUSTING TABLES.

This school has taught Chiropractic for 13 years, having the largest enrollments, and has seen several attempts of inventive students to originate a compact device that would combine small size with light weight, great strength, solidity, and be practical. The illustrations are of a folding suit case adjustable table. THE CHIROPRACTOR'S editor and the professors of The P. S. C. have seen, purchased, tried and dismissed several forms at different times, because each had weak points.

It remained for 1907 to patent a table that measures 27x16x4 $\frac{3}{4}$  inches, weighing 20 pounds. B. J. Palmer, D. C., Ph. C., one of the patentees, has tested this work bench with 1,600 lbs. of live weight and has not found it wanting. They are guaranteed to stand the weight of any patient that can be placed upon them, and all the strain that will be given it.



The P. S. C. "CHIROPRACTIC'S FOUNTAIN HEAD" has received many calls for a table that in weight was light enough for any Ann Elizer (Lady Chiropractor) to carry from the office to a home; a thing of beauty which would be practical in the office, 365 days in the year, as at a residence on a hurry call. Made of quarter-sawed oak, given a polish, and a better piece of workmanship or investment for the Chiropractic profession could not be purchased. A Chiropractor is losing money to be without one. They are the insignia of his business; are not adapted for osteopathic "manipulations," but just the thing for a D. C. or Ph. C. They are to him what the "medicine case" is to the M. D.



Its shape, dimensions and outlines meet the approval of this school in every respect. They are fully protected by patent and any and all infringements will be prosecuted. The price is insignificant compared to their workmanship and daily value. Orders will be delivered promptly. Price \$18, including packing and crating. Make all Money Orders or Drafts payable to

ADDRESS ALL CORRESPONDENCE TO B. J. PALMER D. C. PH. C.

**THE PALMER SCHOOL OF**  
**CHIROPRACTIC**  
(REG. U. S. PAT. OFF.)  
**"CHIROPRACTIC'S FOUNTAIN HEAD"**  
(REG. U. S. PAT. OFF.)  
**DAVENPORT, IOWA, U. S. A.**



## PRICE LIST OF CHIROPRACTIC LITERATURE.

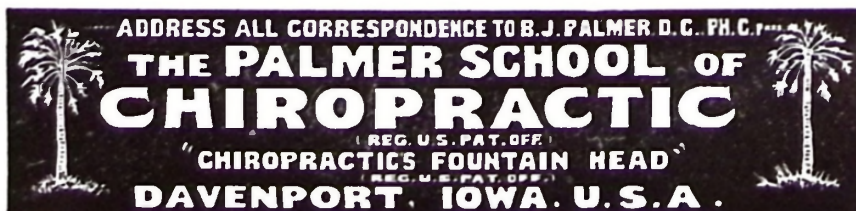
Form.

15. "Cancers, their Cause and Cure." "The Difference." "Child Bed Fever."
20. "Chiropractic vs. Therapeutics."
27. "Take Off the Brake." "Sensible Suggestions." "Humane Education."
29. "Dr. T. H. Story Mysteriously Disappears."
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31. "Rheumatism." "How Osteopathy Treats the Blood." "Who Discovered that the Body is Heated by Nerves During Health and Disease?"
32. "Chiropractic Reflections." "A Line Shaft." "Sworn Statement of Dr. A. P. Davis."
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Samples of these printed forms mailed upon receipt of 10 cents.

On all forms we print your name and business address instead of our own. Bear in mind that all our literature has been, and is, copyrighted.

Enclose money order or draft with your orders.



**PARTIAL PRICE LIST OF OSTEOLOGICAL SPECIMENS.**

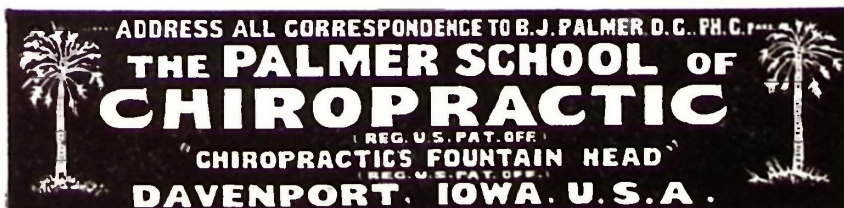
NAME.	PRICE	
	1st Quality	2d Quality
Mounted Skelatons, from .....	\$35.00	to \$75.00
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Skulls, from \$5 to \$21.		
Atlas .....	\$ .75	\$ .50
Axis .....	.75	.50
Carpal, each .....	.30	.20
Clavicle .....	.75	.50
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Sacrum .....	1.50	1.00
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Sternum .....	1.00	.75
Tarsals, each .....	.40	.30
Tibia .....	1.50	1.00
Ulna .....	1.00	.75
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For bones of young subjects showing epiphyses add 50 per cent to the first quality, and bones of aged subjects showing senility add 50 per cent to first quality price. Spinal columns, normal, \$8 to \$15.

The stock of pathological and anomolous specimens and abnormal spinal columns for sale by this school is constantly changing, thus it is impossible to print accurate and complete quotations. Typewritten lists kept up-to-date are for the asking.

The Sales Department of this school sells everything necessary for conducting a successful Chiropractor's profession, including adjusting tables, spinal columns, skeletons, literature, etc., etc.

If there is anything you wish that is not listed bear in mind we have it or can get it on short notice.



## LOOK THIS WAY, PLEASE

MEMBERS OF THE U. C. A. and CHIROPRACTORS EVERYWHERE. The P. S. C.'s photographer has been working overtime to give you all an opportunity to hear and see a few CHIROPRACTIC LECTURES, illustrated with STEREOPTICON SLIDES. These have been specially coined for Chiropractic work. "Nothing but the best" should be your slogan, and when you stack up your dollars against the quick delivery of knowledge that these slides will render possible you will give The U. C. A. the right kind of a boost, and continue to push until you all land on time with "That Smile that Won't Come Off."

THE P. S. C. now possesses over 4200 slides, and they will be yours, unreserved, while attending this convention, and if you like them as well as the students, you can have all you want. Anatomy, physiology, palpation, adjusting, nerve tracing on the living body, diseases illustrated by the hundreds, etc., are but a few of the wide range of subjects illustrated. Some prove the inferiority of treating effects, and the balance prove what adjusting causes will and can do.

## BEGIN NOW

to arrange your work, save a quarter, fifty cents, or one dollar each day, and then be with us to see that we make good when we say this feature alone is WORTH THE ENTIRE TRIP, whether from Maine or California. IT IS FUTURE MONEY IN YOUR POCKET to know how to solve "those hard problems and adjust those cases I failed on." The P. S. C. has been succeeding greater each year, and while you can't get in all in a three-day convention, you can get such a meal that you will digest it for months.

The P. S. C. is filling the market and teaching the public WHAT specific, pure, unadulterated and philosophical Chiropractic IS. We are setting a pace and it is pressing the moss backs mighty hard. It's no secret now that The P. S. C. is the most capable school of creating, inventing, expressing, teaching, personifying, and knowing how to teach their principles and the application of them, and to convince you of their absolute worth in practicability. To know how to do a thing is to be able to do it.

Look at it from all sides and

## DECIDE TO "RUN DOWN THERE"

and see what they have got. You are welcome whether a graduate of this school or any other. The invitation is broad, and extended by the U. C. A. (not The P. S. C.), which is UNIVERSAL in feeling and hospitality as well as name.

The right kind of a philosophical, up-to-date knowledge never runs amiss, and always comes in mighty handy. Hitch that with The P. S. C. ability of how to, and being able to deliver the results, and you have a team that cannot be matched.

IF YOU FEEL LAME upon any point LET THE P. S. C. ADJUST IT. If not a member of the U. C. A. hurry up and get in the band wagon. It don't cost one cent more today than tomorrow, when you will wish you had. If you are not getting enough of the world's goods, if you wish to do more, and don't get it to do it with, then come, get in line and help us, attend the mental feasts which will be spread at the U. C. A. Convention, the first Tuesday, Wednesday, and Thursday in September, 1908.

GET IN LINE, AND ATTEND THE

**U. C. A. CONVENTION, SEPT., 1908**

TO BE HELD AT THE PALMER SCHOOL OF CHIROPRACTIC

"CHIROPRACTIC'S FOUNTAIN HEAD."

DAVENPORT, IOWA. U. S. A.



## THE P. S. C. BUREAU OF INFORMATION.

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To advance the interests of Chiropractic, in general, is the aim of all that this school does. We wish your aid in covering the postage expense involved in a personal accomodation.

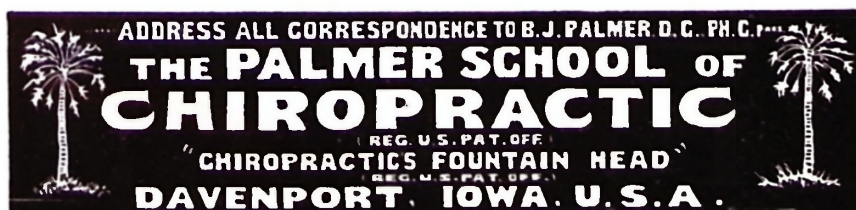
Two years ago *The P. S. C.* advanced the policy of advising prospective patients to go to the nearest Chiropractor in preference to coming here. This policy has doubled our present income for the student appreciates our generosity and speaks well of the school in return. The school is our aim, therefore the above determination to **make the student or graduate a success**, returns with the welfare of the school that backs him.

If you are a Chiropractor and wish to be listed, write us, *The P. S. C.* men will be given the preference. Inquiries come from all states, cities and villages. In many of them we have not as yet a *P. S. C.* man. If a graduate of some other school does live there and he uses goods, that we can conciously recommend we will take pleasure in replying with his address. We have referred hundreds to *P. S. C.* graduates, if listed you will get some of them.

This school has become an exchange for people going from one city to another and inquiries along that line will be cheerfully answered, **provided**, the student has a postage book here and he is an honorable man and using reliable, specific, pure and unadulterated philosophical goods. We have and will continue to give the desired information as to just what the qualifications are of every man inquired about.

The favor is yours. Show **your** appreciation by paying the postage involved to further your interests. Send a stamp book with **name and address pasted on the outside** and they will be used to further **your** patient business.

Patients wishing a Chiropractor write to *The P. S. C.* Give population of town; size of surrounding places; fare between them; whether there has been a Chiropractor, if so, name and state what success he had. Mention what can be depended upon as a starter. Is your city conservative or liberal to new ideas? Give good general unprejudiced information and opinions as can be relied upon.



**THE CHIROPRACTOR,**

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